Board of Directors (Part 1) - 08/04/2025

Tue 08 April 2025, 09:30 - 13:30

MS Teams

Agenda

09:30 - 09:50
20 min

1. Patient Story

09:50 - 09:55
5 min

2. Formalities

- 1a DRAFT Agenda DCH BoD Part 1 April 2025.pdf (3 pages)
- 1b Draft Minutes BOD Part 1 11 02 2025 MF.pdf (35 pages)
- 1c Action Log BoD PART 1 April 2025.pdf (1 pages)

09:55 - 10:00
5 min

3. Chair's Comments

10:00 - 10:10
10 min

4. CEO Report

- 4. CEO Report April 2025 Final.pdf (6 pages)

10:10 - 10:20
10 min

5. Quality Committee Assurance Report

- Assurance Report QC 25 February 2025 - DD.pdf (2 pages)
- Assurance Report QC 25 March 2025.pdf (2 pages)

10:20 - 10:30
10 min

6. Maternity Safety Report

- 5.2a Front Sheet Maternity Neonatal Report for Board April 2025.pdf (2 pages)
- 5.2b Maternity Neonatal Board March 2025.pdf (21 pages)

10:30 - 10:40
10 min

7. Learning from Deaths Q3

- 5.3 24-25 Q3 Learning from Deaths Report_ Board.pdf (26 pages)

10:40 - 10:50
10 min

8. Quality Committee in Common Proposal

- 5.4a Development of Quality Committee in Common - TOR for Approval Board April 25 (002).pdf (5 pages)
- 5.4b AppendixBi Quality Committee Dorset County NHS Foundation Trust Final Draft.pdf (5 pages)
- 5.4c Appendix Quality Committee Dorset HealthCare University NHS Foundation Trust Final Draft.pdf (5 pages)

10:50 - 11:00
10 min

9. Finance and Performance Committee Assurance Report

- 6.1 FPC March 25 Assurance Report V2 Draft.pdf (3 pages)

11:00 - 11:10
10 min

10. Balance Scorecard (incl. elective tiering)

- 6.2 Board Balanced scorecard report April 25 meeting.pdf (14 pages)

11:10 - 11:20
10 min

11. Finance Report

- 6.3a Front Sheet DCH FPC M11.pdf (3 pages)
- 6.3b DCH M11 Finance Report.pdf (15 pages)

11:20 - 11:30
10 min

12. Update on Finance and Operational Plan 2025/26

- 6.4a Operational Plan @270325 Board Front Sheet.pdf (2 pages)
- 6.4b Joint 25-26 Financial and Operational Plan 27 March 25.pdf (16 pages)
- 6.4c Appendix 1 - Section B Provider Assurance Statements 26 March 2025 Dorset County Hospital.pdf (5 pages)

11:30 - 11:40
10 min

Coffee Break

11:40 - 11:50
10 min

13. People and Culture Committee Assurance Report

- 7.1 PCC March 25 Assurance Report - Joint FW.pdf (4 pages)

11:50 - 12:00
10 min

14. Gender Pay Gap Report

- 7.2a DCH Gender Pay Gap Report 2024 Front Sheet and Report - TB.pdf (9 pages)
- 7.2b Appendix A Gender Pay Gap infographic DCH (002).pdf (1 pages)

12:00 - 12:10
10 min

15. NHS Staff Survey Results

- 7.3 DCH Staff Survey 2024 Front Sheet and Report - TB.pdf (19 pages)

12:10 - 12:20
10 min

16. Equality, Diversity and Inclusion Annual Report

- 7.4a DCH EDIB 2024 Annual Report - Front Sheet - TB.pdf (2 pages)
- 7.4b EDIB Annual Report for 2024 - approved.pdf (14 pages)

12:20 - 12:30
10 min

17. Strategy, Transformation and Partnership Committee Assurance Report

- 8.1 STP Assurance Report March 2025.pdf (3 pages)

12:30 - 12:45
15 min

18. Digital Recovery Plan

- 8.2 DCH Digital Recovery Plan Report STP CiC March 2025.pdf (7 pages)

12:45 - 12:55

19. Audit Committee Assurance Report

10 min

- Assurance Report DCH Audit Committee 27 March 2025 - SP.pdf (2 pages)

12:55 - 13:00
5 min

20. Going Concern Statement

- 9.2 Going Concern including front sheet 2024-25 v2.pdf (6 pages)

13:00 - 13:10
10 min

21. Charitable Funds Committee Assurance Report

- 10.1 Assurance Report - DCH Charitable Funds Committee (18.3.25).pdf (2 pages)

13:10 - 13:15
5 min

22. Constitution Review (including Standing Orders)

- 10.2a Front Sheet and report - v2 - Trust Constitution Review - DCH.pdf (12 pages)
- 10.2b DCH_Constitution_v2_February 2025.pdf (96 pages)

13:15 - 13:15
0 min

23. ICB Board Report

- 11.1 ICB Board Report to Partners Part One 160125.pdf (2 pages)

13:15 - 13:15
0 min

24. Guardian of Safe Work Report

- 11.4a GoSW_FRONT PAGE 2425 Q3.pdf (2 pages)
- 8b GoSW_MAINPAPER 2425 Q3.pdf (7 pages)
- 8c GoSW_APPENDICES 2425 Q3 (002).pdf (3 pages)

13:15 - 13:15
0 min

25. Joint Strategy Enabling Plans

- 11.5a Front Sheet - Enabling Plans v2.pdf (3 pages)
- 11.5b Joint Estates and Facilities Eanbling Plan March 2025 v1.pdf (11 pages)
- 11.5c Clinical and Quality Plan March 2025 BOARD.pdf (8 pages)
- 11.5d FPC CIC Finance Enabling Plan 24 03 25.pdf (11 pages)

13:15 - 13:15
0 min

26. DCH SubCo Ltd Q3 Performance Report

- 11.6a DCH SubCo performance report Front Sheet.pdf (2 pages)
- 11.6b DCH subCo Performance Report January 2025.pdf (3 pages)

13:15 - 13:20
5 min

27. Questions from the Public

13:20 - 13:20
0 min

28. AOB

Dorset County Hospital
NHS Foundation Trust

Meeting of the Board of Directors (Part 1) of Dorset County Hospital NHS Foundation Trust Tuesday 8th April 2025 at 9.30am to 1.20pm Board Room, Trust Headquarters, Dorset County Hospital, Dorchester and via MS Teams

AGENDA

Ref	Item	Format	Lead	Purpose	Timing
1.	**Patient Story**	Presentation	Dawn Dawson	Information	9.30-9.50
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Information	9.50-9.55
	a) Apologies for Absence:	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 11 February 2025	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Information	9.55-10.00
4.	**CEO Report**	Enclosure	Matthew Bryant	Information	10.00-10.10
5.	**Quality**				
5.1.	**Quality Committee Assurance Report**	Enclosure	Claire Lehman	Assurance	10.10-10.20
5.2.	**Maternity Safety Report** (March QC)	Enclosure	Dawn Dawson (Jo Hartley)	Assurance	10.20-10.30
5.3.	**Learning from Deaths Q3** (March QC)	Enclosure	Rachel Wharton	Approval	10.30-10.40
5.4.	**Quality Committee in Common proposal**	Enclosure	Jenny Horrabin	Approval	10.40-10.50
6.	**Finance and Performance**				
6.1.	**Finance and Performance Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	10.50-11.00
6.2.	**Balanced Scorecard (incl. elective tiering)**	Enclosure	Anita Thomas Executives	Assurance	11.00-11.10
6.3.	**Finance Report** (March FPC)	Enclosure	Chris Hearn	Assurance	11.10-11.20
6.4.	**Update on Finance and Operational Plan 2025/26**	Enclosure	Chris Hearn Anita Thomas	Information	11.20-11.30
Coffee Break 11.30-11.40					
7.	**People and Culture**				
7.1.	**People and Culture Committee Assurance Report**	Enclosure	Frances West	Assurance	11.40-11.50
7.2.	**Gender Pay Gap Report** (March PCC)	Enclosure	Nicola Plumb	Approval	11.50-12.00
7.3.	**NHS Staff Survey Results**	Enclosure	Nicola Plumb	Assurance	12.00-12.10

	(March PCC)				
7.4.	**Equality, Diversity and Inclusion Annual Report** (March PCC)	Enclosure	Nicola Plumb	Approval	12.10-12.20
8.	**Strategy, Transformation and Partnership**				
8.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Enclosure	David Clayton-Smith	Assurance	12.20-12.30
8.2.	**Digital Recovery Plan**	Enclosure	Nick Johnson	Assurance	12.30-12.45
9.	**Audit Committee**				
9.1.	**Audit Committee Assurance Report**	Enclosure	Stuart Parsons	Assurance	12.45-12.55
9.2.	**Going Concern Statement** (March AC)	Enclosure	Chris Hearn	Approval	12.55-1.00
10.	**Governance**				
10.1.	**Charitable Funds Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	1.00-1.10
10.2.	**Constitution Review (including Standing Orders)**	Enclosure	Jenny Horrabin	Approval	1.10-1.15
11.	**CONSENT SECTION**				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
11.1.	**ICB Board Report**	Enclosure	David Clayton-Smith	Information	
11.2.	**Guardian of Safe Work Report** (March PCC)	Enclosure	Rachel Wharton (Jill McCormick)	Assurance	
11.3.	**Joint Strategy Enabling Plans** (March STPC)	Enclosure	Nick Johnson	Approval	
11.4.	**DCH SubCo Ltd Q3 Performance Report** (March FPC)	Enclosure	Nick Johnson	Information	
12.	**Questions from the Public**	Verbal	David Clayton-Smith		1.15-1.20
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk				
13.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Information	1.20
14.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of **Dorset County Hospital NHS Foundation Trust** will take place at **9.30am** on **Tuesday 10th June 2025** in **Trust HQ Boardroom and via MS Teams.**				
	Resolution Regarding Press, Public and Others: To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the				

	public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

Quorum:
The quorum of the meeting as set out in the Standing Orders of the Board of Directors is below:
"No business shall be transacted at a meeting unless at least one-half of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present."

Part 2 Items

- Chair's Comments
- CEO Update
- Finance Update and Operational Plan Update
- Cyber Security Update
- Dorset Shared Services Business Case
- Dorset Procurement Business Case
- Consent items:
    - One Dorset Provider Collaborative Minutes
    - Business Case – New Hospital Programme Generators
    - Renal Dialysis Unit Refurbishment
    - DCH Fortuneswell Pharmacy Development and SubCo
    - Key Worker Housing Strategy

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 9.30am on 11th February 2025 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Margaret Blankson	MBl	Non-Executive Director (via videoconference)
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Alastair Hutchison	AH	Chief Medical Officer (via videoconference)
Nick Johnson	NJ	Deputy Chief Executive and Joint Chief Strategy, Transformation and Partnership Officer
Eiri Jones	EJ	Joint Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non-Executive Director
Stuart Parsons	SP	Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
Anita Thomas	AT	Chief Operating Officer (via videoconference)
Stephen Tilton	ST	Non-Executive Director (via videoconference)
David Underwood	DU	Joint Non-Executive Director
Frances West	FW	Joint Non-Executive Director
In Attendance:		
Abi Baker	AB	Corporate Governance Manager
Kara Ellis	KE	Corporate Governance Officer (observing)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs (via videoconference) (Minutes)
Judy Gillow	JG	Non-Executive Director, University Hospitals Dorset (observing) (via videoconference)
Jo Howarth	JoH	Director of Nursing (Acute Care)
Paul Lewis	PL	Joint Director of Strategy and Improvement (item BoD24/217)
Ramin Shahnan	RS	Staff Story (Item BoD24/199)
Members of the Public:		
Alan Clark	AC	Governor (via videoconference)
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Tim Limbach	TL	Governor (via videoconference)
Apologies:		
Matthew Bryant	MBr	Joint Chief Executive
Dawn Dawson	DD	Joint Chief Nursing Officer
Rachel Wharton	RW	Chief Medical Officer Designate

BoD24/199	**Staff Story**	
Baker Abi 02/04/2025 16:28:00	NP introduced RS, a healthcare support worker in the theatres team at Dorset County Hospital (DCH), who arrived in the UK as a refugee from Afghanistan in 2022. RS thanked the chair for the opportunity to share his story. RS outlined that prior to joining the Trust he had been working in the Afghanistan military as an engagement officer at the UK embassy. He described his experience of the events of 15th August 2021 when the Taliban took control	

	of Afghanistan, how we went to work as normal, but that people were acting strange, and that it soon became clear that life as he knew it was over, and he had to leave. RS described the chaotic scenes in the streets, his efforts to escape to the airport with his wife and how he had no choice but to leave his family behind. RS told the meeting about his past experience of studying abroad in many difference countries when he was young, and that his wife had recently passed her military commissioner course in the UK and had just returned to Afghanistan. Despite this, they lost their jobs, families and country on 15th August 2021. After five days RS and his wife got to the airport, but they became separated in the process. RS's wife was sent to Dubai and then to the UK, while he was sent to Qatar. After three months RS was sent back to Kabul, where he walked by himself to the Pakistan border. He was later able to get a flight from Pakistan to the UK in a military aircraft. Six months after the Taliban took over RS was reunited with his wife in the UK and they initially stayed in a bridging hotel in Exmouth. In July 2022, RS and his wife were offered a house to rent in Dorchester. Upon arrival their feelings were mixed; relieved to have found housing, but worried about what would happen next. RS described that Dorchester was expensive, it was a struggle to find halal meat, and it was difficult to find a job, but he felt safe here. RS was able to find a job in the NHS with the support of the DCH widening participation team, who helped him with a care certificate scholarship, classes and training, with the application process and interview skills. RS extended his thanks to Tom Gordon (TG) and the widening participation team for their support in this regard. RS summarised that the hardest time in his life was not being able to say goodbye to his mother, father, and sister, but that he had no other option. He did not want to be an immigrant, but he had had to leave his family, childhood and dreams behind to be safe. He was now happy to be a citizen in Dorchester and to be working with DCH. CL asked RS how he and his wife were finding working for DCH and whether it was a supportive environment. RS confirmed that it was a supportive environment and described that he had contacted the Trust after finding information online about healthcare support worker roles, and he had been supported from the beginning by the widening participation team, his manager and his colleagues. Board members asked how the Trust could better access a broader, more dynamic workforce, and what more the Trust could do to support staff who come from abroad. On the former point, RS described that he and TG were attending Department of Work and Pension seminars to share RS's experience in how he joined the Trust. On the latter point, RS reflected on the many different cultures at the Trust, but that everyone had the same rights and managers were supportive. When asked about his wife, RS confirmed that she also worked at the Trust but was currently on maternity leave as she had recently given birth to their first son, who had been born at the Trust.	

	EJ noted the difficulty with finding halal food, and asked if there was a community outside the hospital who could help with this. RS noted that he did have help from DCH for the first 2 years but that this had now ended. He and his wife travelled to Bournemouth approximately once a month to buy halal meat and would freeze it. NP thanked RS for sharing his story with the board and more widely, and how it inspired people. NP noted that the widening participation team comprised of just two people and that 200 people had been helped through the initiative. NP further reflected on the Trust's role as an anchor institution and in reducing inequalities. RS said that he loved to help people and making a difference in people's lives. He further noted that he was hoping to be redeployed to another department in the Trust due to flashbacks of his military work that he was experiencing. Board members thanks RS for his time, and RS left the meeting.	
	Resolved that: the Staff Story be received for information.	
BoD24/200	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Matthew Bryant, Dawn Dawson, and Rachel Wharton.	
BoD24/201	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD24/202	**Minutes of the Meeting held on the 10 December 2024**	
	The Minutes of the meeting dated 10 December 2024 were approved as an accurate reflection of the meeting, subject to a minor amendment.	
	Resolved: that the minutes of the meeting held on 10 December 2024 were approved.	
BoD24/203	**Matters Arising: Action Log**	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items. It was note that some items on the action log were not yet due, and others were covered on the agenda. Reflecting on the challenges of the year ahead, particularly in relation to headcount, EJ sought further detail on the previously agreed uplift in headroom for safe staffing. JoH advised that this had not yet been received. The request had been through the last cycle of business planning and there had been a request to model a targeted approach to implementing that headroom. A paper was being presented to this week's Joint Executive Management Team meeting (JEMT) with a proposal that would reduce agency and bank usage. EJ raised concern that the uplift had not yet happened, noting that headcount was a safety issue, and that the next financial year would be	

	even more difficult. JoH was clear that although the uplift in headroom had not yet been implemented, the Trust was not compromising on safety as temporary staffing was being utilised to ensure safe staffing levels and clinical demand.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD24/204	**Chair's Comments**	
	DCS highlighted the busyness of the hospital during winter and the work of executives to address the recently released 2025/26 planning guidance. He stressed that finances would continue to be tight in the new financial year, and that the Board would need to continue to have oversight of this. Additionally, the Chair of the Integrated Care Board (ICB) was leaving at the end of March. Amongst all this change, the Board needed to maintain a focus on providing safe and quality care to patients. The Board will also need to keep a focus on transformation over the coming year. Board members will need to support executive colleagues in making difficult decisions and to ensure that sufficient and robust review had gone into these. Reflecting on his work since the last meeting, DCS highlighted: • Consultant interview panel • Quality walkarounds • A meeting with NHS Confederation in which he was able to explain the work of the federation, with the focus on integrated care. • Coffee runs at various sites in which he was able to talk to staff about the joint strategy • Continued contact with the leader of Dorset Council, Nick Ireland, who used to be a Dorset HealthCare (DHC) governor • He had attended a regional planning talk where the 10-year plan was discussed. DCS noted the balance between transformation, focus on patients, and financial constraints. DCS reflected that the next twelve months were likely to be the most testing for the board, but that colleagues would do their best to support each other.	
	Resolved: that the Chair's comments be received for information.	
BoD24/205	**CEO Update**	
Baker Abi 02/04/2025 16:28:00	NJ highlighting the following key points for the Board. • The Trust had been in an incredibly pressured period since Christmas. NJ extended his thanks to all staff and to executive colleagues for their hard work • Publication of operational guidance, elective care guidance and neighbourhood guidance. Each of these were being received and the Trusts' response to them developed. • The focus of the operational guidance was in-line with previous years, with finances expected to be incredibly difficult and a stronger focus on breaking-even. Plans must be fully owned and signed off by Boards	

- Interim CMO was in place and was working through the handover period alongside current CMO and noted the changes to the executive team.

NJ reported that there was a lot going on nationally, operational guidance, elective care guidance and neighbourhood guidance had been received, and the teams were working hard to review and respond to those.

CH gave an update on operational business guidance. The number of national priorities for 2025/26 has been reduced, but the focus was the same as previous years.

Finances are going to be incredibly difficult going to next year and the message was that we must live within our means. We need to determine what we need to do to breakeven rather than what do to deliver things. There is reference in the planning guidance for board to sign contract to breakeven which is something new and we haven't seen yet. They are asking the Board to sign up to those plans.

Locally we are meeting regularly with system regional colleagues regarding this year's delivery and CH and others will provider updates later on detail. We continue to make progress

In reference to the local government devolution, Dorset, BCP and Wiltshire applied to create a strategic authority for Wessex, but this was not approved to be part of the devolution priority programme. The line from the Local Authority is that this is not the end of the conversation, and the Government are still keen to engage and while the bid met all criteria, there were only so many places available.

NHP has reached a significant milestone, and we have now formally entered in to contract with Tilbury Douglas for the main build and we will be communicating plans for works commencing over coming weeks including changes to how ED access will work for patients and visitors as well.

From the Integrated Neighbourhood Teams (INT) perspective, we are making good progress on that, roughly 150 people from across system met in mid-January to discuss the plans for INTs and there was a sense of momentum in the room. Neighbourhood guidance was recently issues and lots of things we doing in INT is reflected in guidance and a good reflection of the work we are doing. NJ attended a neighbourhood policy setting meeting with the NHS Confederation in London which brough together a host of people working on this in NHS and beyond. Herad about other colleagues and pleasing to see where are compared to others.

It is not included in the report but hosted Adam Dance, MP for Dorchester South and Somerset last week to talk about plans for stroke services, linked to reconfiguring of services within Somerset which obviously caused concerned. Whilst he continued to be concerned about changes in Somerset, he was impressed with the team and the work being done to prepare for that and encouraged us to shout more and celebrate the work the Stroke Team had done. We got a SSNAP score A from that and a

	small example of that was how we continue to improve and meet challenges despite pressure. Final thing in report that Rachel Wharton joining us as interim CMO and slowly taking over from AH and this obviously made this AH's last Board. NJ noted there would also be other opportunities to thank AH for his contributions to the Trust. FW noted that in the opening paragraph we have highlight key priorities and around hospital or communities being key. There is a lot in news about bed numbers compared to France or Germany per head of population. FW asked if we try to make services fit money or beds available or has some analysis been done of what requirement be. We talk about flow, all conundrums but are we trying to squash patients into an envelope that is not appropriate and what do we actually need. Are we looking at changing service configuration around this community effort. AH advised that as we had left the EU, data is not coming through on regular basis to us. The last set of reliable data came out in 2021 and at that point it showed all European countries reducing bed bases but beds per 100,000 population, we were 3 from bottom out of 28 countries. The number of nurses and doctors will mirror that. The sad fact is that the NHS is an unplanned service. We don't have workforce plan, and there isn't a bed plan. Very few new hospitals are being built, so there is a continuous decrease in the number of beds which most people now feel has gone too low. NJ said it was fair to say we are low on comparator metrics and actual in the NHS and the South West, and then the SW lowest number in the region. The reality is we have to plan in an envelope, we can have low bed numbers if we have the right provision out of hospital. We are planning in hospital regarding the number of beds we think we may need, as we have done that demand and capacity planning, so we are doing that from a hospital perspective but then we have to look at how we balance that with finances. AT confirmed that we had undertaken an analysis in the number of beds we need, but that analysis also recognises that there was more we could do to reduce the length of stay in elective and non-elective care to offset the population increase. We care completing a detailed analysis with Newton, Future Care Programme, which looks at this system and compares it with others and recognise that we have a lot of beds in the system, but they are not necessarily the right beds in the right places with the right care to support better flow. That underpins the future care programme we are involved in over next 18 months and a lot of that focuses on issue prevention from escalation of treatment needs and how quickly we can get people home. CH agreed with NJ and AT. There is something about the productive bed base we have, linking into the no criteria to reside and the number beds required flexes depending on productivity of beds we have. That is where INT work and provision at place comes in as important too.	

	MBI said that she would be really interested to hear more about the shared vision tools in the report, especially given the level of engagement from Board members and wondering what key themes have emerged so far, so we can understand the process taking place between now and end of February. NJ replied that we haven't collated key themes yet, and we have reference to this within the strategy improvement report. In some ways the answer to that question will be dependent on what people heard on their visit and the feedback they getting. NP added that is where we started with INT, what do we think we need, and we come back to the discussion about bed base. NP recalled a conversation with Bruce Keir, Medical Director, who said that if we went back 100 years the fundamental model of care has not changed. The people that are in the beds are unwell. It is still same. The challenge for us in revisioning where we are going is how do we move that. It is not a new thing but yesterday NP sat in programme board for INT and unless we can move the dialogue on to new space we are talking about existing models of care. The challenge for us to stay in the space that we can't end the year having those same discussion. We have to try to get ourselves in to place. DCS said that we would gather together the feedback, but the conversations that he was having around this, people know that we need to change, it just knowing how we going to change it and with the vehicle of INT and the way it works with other partners, it might be a powerful way to demonstrated that there is a different way to do this. We will need to come back to this topic and revisit. EJ wanted to respond to NP's point. Fully support and heard of some good examples of HAH pathway in Somerset, of an elderly frail person who was able to stay home and get right care. What concerned EJ was about the danger that we may start to think we'll never need hospital beds, but there will still be people who will get very ill, and the hospitals we are left with in future must be able to deliver that right care from people with the right skills. We still want and need to provide very good quality care. DCS agreed and said that was part of the tough decisions we would need to make, on what services we could and could not provide.	
	Resolved: that the CEO Update be received for information.	
BoD24/206	**Board Assurance Framework**	
Baker Abi 02/04/2025 16:28:00	JeH advised that the Board Assurance Framework had been presented to committees during January and had undergone a thorough review at each stage of the assigned risks. We need to do a little bit more work regarding formatting and assigning key metrics to risk and that tied in with work on strategy and metrics. SR3, SR5, SR6, and SR9 are the highest risks and all those are consistent with things on the agenda and consider highest risk. What should be noted is that following Committee discussion, SR9 has increased from 12 to 16 following SPTCIC. All amendments on all individual risks are shown	

	in red so you can see the change one month to next. We will continue to develop these from feedback. There are a small number of actions from risk that have not been implemented by the due date, these are highlighted in amber, updated including a revised implementation date, but there are no major concerns there. DCS commented that it may be good to follow the life of a risk at a workshop. It is pleasing to see that they are discussed at Committees, but it would be good to see what happens, how it is mitigated and where comes through. ST recalled it being mentioned at Finance and Performance Committee in Common and Audit Committee but wanted to thank JeH for making the risk section much more open and transparent and easy to view and see what going on. SP wanted to touch on the escalation reports but noted that committees are assured because of work going in in new format and red updates. He would echo ST's comments but share DCS's view that it would be good to work through one score for reassurance about process, that we have a clear action plan and can demonstrate to governors there is good scrutiny across committees with culmination at Audit Committee. NJ agreed with ST and SP. The Board Assurance Framework in really good place at the moment and thanks to JeH it gives us some transparency visibility on risks, and we can think of it in really practical terms e.g. we took a report to Strategy, Transformation and Partnership Committee in Common on the digital capacity and capability piece, partly driven by NEDs and Board committee identifying some risk from Corporate Risk Register and what the Board Assurance Framework is looking like, so we are able to respond in real time to that. This is starting to make a difference to how we are working.	
	Resolved: that the Board Assurance Framework be received for assurance.	
BoD24/207	**Corporate Risk Register**	
Baker Abi 02/04/2025 16:28:00	JoH took the report as read. These risks come through Committees too and are playing through in the digital risk discussion. Colleagues should note that a theme coming through People and Culture Committee in Common and Quality Committee around digital infrastructure workforce capacity and ability to deliver transformation in that space. The report summarised new risks reporting in quarter. JoH would like to reaffirm, although there are some formatting issues, we have had some change in the risk team and we are working though those. We have undertaken a data cleansing exercise and significantly reduced the number of risks that will come through in q4 report. We still intend to feedback from committees and that we have taken action. DU welcome JoH's comment. At Finance and Performance Committee and Audit Committee we noted that in regard to the Corporate Risk	

	Register there was some farming to be done. There were a number of risks talking about same issue, but specific e.gs. of it differed. In Finance and Performance Committee in Common we had 44 15+ risks, and when DU went through the detail he felt this should be closer to 10. JoH advised that we were down to 74 from 111 and work continues. Working with the Division to determine whether we have the right level of scrutiny and oversight in the management of risk in the Divisions to ensure we are informing the most appropriate risks to Board. DCS asked if there were any thematic issues picked up, and are we making decisions about how to use resources and whether there any thematic risks JoH responded that at SLG, where we provide update to the management team, digital is playing through number of committees. Two listening events have been held with digital as a consequence of how they are feeling as they are not able to move project work forward. Estates and Facilities have a number of risks relating to fire which echoes DU's comments about replicated risks. In workforce, we are in an improved position as recruitment vacancy activity is low now. However, it gives a challenge regarding apprentices due to quality and commitment to roles. We have shifted in workforce broader risks we are facing high vacancy rates and we are now seeing those risks in infrastructure areas. CH again added that it was all linked to DU's point about amalgamation of risk and a degree of duplication. Each committee reviewing a risk will have a different lens to view them through, E.g. estate risks hits all committees in different ways. Once we have refined the risks over time, we will be able to streamline them. NJ noted the large number of digital risks and JoH had undertaken listening events which was important. We referenced the STPCIC paper on capacity and capability of the service. We need more focus on the medium to long term solution approaches. What we are doing in the short term as a team is reviewing all risks and actions to be taken and working this up in to a recovery plan for next year for digital services in DCH via JEMT and suggest this goes to the Strategy, Transformation and Partnership Committee in Common and Board as a consent item. JoH advised that we had an Internal Audit of risk management in 2023 which had a number of recommendations. We are revisiting those to make sure the recommendations are embedded and part of those were having a robust risk management training programme, so we are clear about what to record and score risks etc. We are actively working with DHC on an education programme about how make sure have easily accessible robust risk management training program in place for service manager and clinicians. SP raised a minor point around a formatting issue that had not been picked up in committee. If you look at the Executive Summary overview of risks, there are some dates that are incorrect. These should be correct as this is a public document.	

	Resolved: that the Corporate Risk Register be received for assurance.	
BoD24/208	**Quality Committee Assurance Report**	
	CL advised that this was the escalated items from the meeting 17th December 2024. It was noted that the meeting was not quorate at start of meeting and developed subsequently. Highlighted that the Committee was changing to a committee in common and they were mindful of numbers to see how often non quoracy happened during the evaluation of process. Significant matters to raise were the issues in ophthalmology relating to patients lost to follow up. This was being pursued, and a paper was going to the next Quality Committee of the issues and mitigations, so this was on the radar for awareness. The Committee acknowledged the significant operational pressure awl services were under and that this may have an impact on quality. We took assurance regarding the winter plan and mitigating risks and were mindful of the quality impact and a report will come back to future committee to review. There were some good news stories. We achieved the first successful SSNAP stroke audit in 4 years and the SHMI appears to be moving in the correct direction. One discussion at committee was that it would be good to have an opportunity to focus on the Board Assurance Framework in future development days and how we use that and triangulate differently in different committees. This linked to CH's comment around the different lenses we perceive risks by and to be assured being used and understood consistently. There were no items referred on to other committees from that meeting. DCS commented that on the Board Assurance Framework, with the move to joint Quality Committee it would be good to connect to JeH to make sure the Board Assurance Framework working for Quality Committee in Common. JH responded that SR1 goes to both committees and that possibly in one informal meeting, we could focus on that to see what biggest risk areas are. EJ presented the report form the 28 January 2025 meeting and noted that we were quorate, although she was very mindful of the smaller numbers of members. EJ flagged that when only 2 NEDs were present, even though technically we are quorate, as one NED chairs, the quality of challenge and discussion is harder. SP does brilliant job questioning at Quality Committee but something to be mindful of as we move forward. EJ highlighted that the Trust was fully complaint with MIS. This position had been confirmed by Internal Audit. At the time of the meeting, we did not have feedback from the LMNS and ICB yet, but that has been received	

	since. JoH advised that the MIS report was for noting at the Board today, and that it had been a huge undertaking by the team to achieve full compliance. EJ advised that the risk for not achieving this next year is around neonatal staffing. Concerns remained around digital risks and wondered whether as that was referred to Strategy, Transformation and Partnership Committee in Common from two committees, whether the report, whilst QC gets an overview in the escalation report wonders if the report itself can go back to subcommittee members to read, so that all committees can see the detail. We have appointed the tenth obstetrics and gynaecology consultant which will make a big difference. The other positive was that we were awarded POSCU paediatric oncology status which a real win for a small Trust. One issue to not was in regard to Mental Health s132 rights, in that there was a reduction in compliance but in fact it was because of the new 'right place right care' changes, so this may well be a positive. We will be looking into this more next month. DCS invited questions. ST wished to echo EJ's opening comments in terms of the number of NEDs on committees in common. This was a general concern when we implemented the new arrangements and ST remembered raising this regarding Finance and Performance Committee in Common and thought we decided to have a formal review at some point and that we should think about planning that in. The second point he wished to raise was in relation to the vaccinations for covid and flu. It was raised in the escalation report in December, and he queried if there was any update. JoH advised that we had has a vaccine debrief meeting yesterday. Our flu vaccination rates were 38% with the regional position being 36-40%, rates were lower for covid which was just under 30%, which was similar to regional levels. There were lots of conversations at a regional and national level about how to increase the uptake across the population as well as staff. We didn't have confirmation about staff vaccinations until very late in the seasons. It was not mandated for covid in particular until very late. We are already talking about the approach for the next winter vaccine programme. We are looking at what worked well and where to strengthen the messaging to staff. We have signed up to the spring covid booster for patients which we will be offering through the discharge lounge and frailty SDEC in spring. JeH stated that as a matter of course, we undertake an annual review of Committees, but we said we would review the committees in common after 6 months. After the committees have met in March, we will do the annual committee effectiveness review, as the new committees in common have met 4 times, so there is enough substance for meaningful commentary. We will then report back to the May meetings. We also might include an update on TORs. The effectiveness review annual report will come to May meetings. It is also an opportunity to review membership, and this may shift things from one committee to another. So a review is planned and imminent.	

	FW raised a minor question as to whilst we are doing the review, are we also going to look at recruitment to NED numbers which might give us more flexibility. JeH that was not part of the committee effectiveness review, but that we were also undertaking a constitution review which goes to the next COG meetings and then Board which will look at NED numbers across both. DCS advised that we will need to recruit. EJ made a very good point in that it was difficult to chair and fully participate with a committee. We did say that we would learn and develop.	
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD24/209	**Maternity Safety Report**	
	JoH took the report as read. It provided a summary of quality and safety issues including details of maternity incidents, but also some improvements around particular management of PPH which was an area of concern 12 months ago. We are now well within national limits, and we are sustaining that improvement. We had a number of term admissions, ATAIN data to SCBU remains low and we are performing well in that area. There are 2 risks of note, one around cover for early pregnancy assessment service, and we are reviewing the staffing model and one risk regarding maternity reception cover. We can confirm consultation has taken place and we are in process of recruitment so we will have improved 7-day cover. There is a summary of complaints received included in the data and issues around baby loss. FW asked about the staff sickness, as when looking at sickness levels across the Trust it sits at 4.5% and asked if the drivers linked at all to staff vaccinations, noted SCBU over 11%. JoH advised that since this report, we had seen 7 newly qualified midwives join the service, and q3 is in a better position for staffing. Birthrate plus report has also been through Quality Committee, and it had highly recommended further uplift of midwives and subject to discussion through business planning. This has meant higher rate of sickness, low morale and burnout, but also reflective of national scrutiny relating to maternity services generally. Since report, staffing numbers report with 7 preceptees at the end of September. DU thanked JoH for the report and asked about Risk 1959 p13/20 as wanted to understand it a little better. The solution might be an IT one but is wondering whether it is one that can be delivered in sensible timescale. JH interrogatability migration. Unable to respond regarding timescales but would be happy to follow up outside board. DU noted that we have numerous projects of this sort and if we have to add project to the list of IT projects it may not get done for 18 months to 2 years. DCS noted that it links to the digital capacity work we were talking about earlier. SP noted that this report is gone through pragmatically at Quality	

	Committee, but his personal observation when he undertook a walk around at the time that the weather was really bad, Lindsey was busy making sure team remained calm. SP had really good feedback from two patients. One of whom could have gone elsewhere but choose to come in DCH. One minor point was that he was impressed that he got stopped by member of staff who questioned who he was. are you.	
	Resolved: that the Maternity Safety Report be received for assurance.	
BoD24/210	**Organ Donation Report**	
	AH presented the biannual report, which covers the 6 months to Sept. 2024. From three consented donors, Dorset County Hospital NHS Foundation Trust facilitated two actual solid organ donors resulting in five patients receiving a transplant during the time period. Additionally, four corneas were received by NHSHBT Eye Banks from the Trust. Additionally, there were no missed donor referrals, no occasions when a Specialist Nurse was absent for the donation discussion, and no missed opportunities for best practice. If we look at the national data, none of the Trusts provide more than 4 donors, so it continues to work well and highlights our numbers are good practice. DCS asked from a process point are organs removed and transported. AH advised that the transplantation teams were organised on regional basis so the surgeons coming in to remove organs come from Portsmouth or Bristol. They cover a large area and flex according to what happening on that particular day.	
	Resolved: that the Organ Donation Report be received for information.	
BoD24/211	**Update on Learning from the Children and Young People Flagship**	
Baker Abi 02/04/2025 16:28:00	JoH advised that as part of the Working Together Programme for DCH, there were 4 flagship programmes established 18 months ago. JoH asked to be SRO for children and young people flagship programme and that programme continued in project form with support from the transformation team. They were able to focus on provision and response to children and young people who attend A&E at DCH with social, emotional and MH needs. As background to this, our analysis of data showed 60% in YP attending ED in Dorchester since before the pandemic. Not all of the children had diagnosed MH condition or were in receipt of MH services, but nearly all had a degree of complexity in presentation such as home circumstances, maybe not in education. We continue to feel we can do more in this space. The team joining shortly will take you through slide set from Quality Committee that sets out original main areas of innovation and transformation and also some work ongoing and continue into the next	

	financial year to make sure continue to evolve. Reflecting comments we need to be in different place in years' time and services for children and young people will be in different place relating to the joint working across DHC and LA, and planning for NHP which will have dedicated space for complexity in children and young people. We will continue the work into the new build once it opens. Mike Kelly (MiK) explained that this was one of 4 flagship programmes. There was prescribed methodology for each programme, looking at data design of care models and gateway process and finalisation of care models and plans going forward. We slightly stepped outside that and had people with lived experience involved in workshops from start and had several workshops, with a specific workshop to finalise model. First slide shows the overall aim of programme and coproduction at heart of it. Approach. In terms of the workshops really the topics we covered our voice survey, which review of 1000 YP, views relating to patients and educators and how they manage MH. We looked at the CAMHS transformation programme, heard about family hubs, introduced a 15 step challenge from YP on Kingfisher Ward. We also looked at data as part of this, and over 12 months there were 450 presentations to ED. Not surprisingly most of those between 4pm and midnight for YP. 53% of those were open to MH services and proportion of those ED attendances 31% were seen between 8pm and midnight. Developments. We developed a MH training programme for paediatric nurses based on NHS supported model that Wessex delivered. 13 paediatrics nurses from ED and Kingfisher attended and their confidence level measured pre-programme and post-programme and went from a 3 up to an 8 out of 10 at end of programme. We are working on the delivery of next the prgramme and next cohort. The 15-step challenge resulted in a number of improvements come out of that and action plan being taken forward and benchmarked against the Royal College of Emergency Medicine for patient and service and a group of resident doctors completed and audit in terms of this and highlighted need for improved risk assessment in ED and professional curiosity about presentation. Consultant and advanced nurse practitioners are the best placed to do the risk assessments. Information workstream in train at the moment, action plan for that and the introduction of QR codes in reception which linked to DCH pathways through ED for YP and also information leaflets. We have introduced distraction boxes with self-soothing materials in ED whilst the patient is waiting. We are working with the Dorset Youth Association on development of youth worker model for reductions attendance and attendance. In terms of the new care model of multi-agency triage model, there are two stages, a fast referral process, and a faster being seen by liaison service, with a longer-term aspiration relating to CAMHS and liaison support, and a high intensity user group. The southwest is an outlier in terms of high intensity users presenting to ED and in particular work being done on data	

	reviewing trends. The Head of safeguarding and the ICB are members of the Strategic High Intensity User Group. Workforce. We've talked about a Youth worker in-reach service and undertaken a joint visit to Pebble Lodge in Yeovil. We are looking at shadowing in terms of new paediatric nurses as part of their induction and have the same reciprocal arrangements. We are looking at trauma informed training for ED reception staff. We have a Complex Care practitioner in post who works between ED, Kingfisher and other wards. Funding has been created to employ a MH support worker in ED and set up a support structure that links in with the main DHC support forums. Next steps. A lot of work has done to date but there is still a lot to do. The CAMHS transformation programme and linking with that and business case at the moment around funding for first stage of that and we are awaiting the outcome. That has focus on YP In crisis. We are linking in with NHP design and we will be getting YP involved in the environment once we've agreed the new care model at front door. Dorset Youth Association to support in reach work, that model is moving ahead at pace so implementation in quarter 1. The SOP for MH Area in ED being reviewed along with routine monitoring of metrics. This programme is now business as usual. DCS thanked the team for attending and presenting, and asked how we make sure this is sustained and becomes business as usual. JoH responded that part of challenge in transformation itself is exactly that, about how we keep the narrative going. We are making sure that the story history is not lost, Anna Eckroyd (AEc) came back from NHSE where she was working on this element, so this history has also been maintained, and we are engaging people in conversation. People with lived experience have been involved from the start which has been key. We are also maintaining the engagement with the Kingfisher team, and the ED teams, where there are changes in staff, so we are making sure we are building in those teams as business as usual and that it is not seen as a siloed project programme piece. There is more to be done. MiK added that we have dedicated time to focus on this programme and it feeds into the Mental Health and Learning Disabilities steering group as part of the governance arrangements, so there is good oversight and momentum and a passion for driving things forward. MBI thanked the team for the report and asked if we are seeing an increasing number of CYP or whether we were better at identifying this cohort of patients. She also asked whether we were an outlier in the South West in terms of high intensity JoH advised that we are seeing an increase in attendance, and we have a better understanding of what those attendances are presenting with. Data can be misleading as part of an emergency care data set, for example, someone could come in with ideas of self-harm but not give wider details of why they are feeling like that.	

AEc said that this is one of the areas being looked at across the system and across the Southwest and lot of work done. The work to do date reflects on what the data is showing us rather than why. We are in a good place in Dorset now to uncover more details regarding the whys. We know there is an increase in identifying children and young people with neurodiversity. From the data perspective, we have not had particularly good transparent data and now we are in a different place with new dashboard. We need to focus in around health inequalities and areas of deprivation so can do more targeted work.

NJ stated that this was fantastic work, and he was really impressed. He passed his thanks on to everyone in the team. NJ acknowledged that this was one of flagships under the Working Together Programme. As AEc described there is increasing complexity in healthcare and thinking about not just physical or mental health. but how we look at them together and the whole person. This is a good example of trying to think differently. NJ asked how the Federation and partnership with DCH and DHC helped this and what the potential lessons are we can learn.

AEc stated that this was about two organisations working closely together for the same population and we have really good links and much better working professional relationships across DCH and DHC and that was key in driving this forward. She explained that multiple times in past experience, engaging with other professions from other organisations did not work, but that does.

MiK said we needed to bring different skill sets to it. The driving focus of the team and this programme was dedicated resources, working one a day a week at DCH working on this and mental health services generally really.

JoH added that her reflections, having been there from first day, we probably started from a point of needing to build common understanding and relationships. Although we being encouraged to follow particular methodology, which we slightly ignored, and we did what we felt was right by having people with lived experience in the first workshop. We didn't want to keep service users siloed from clinicians. It was important that we had BI support, and project support. We also had managers in that space.

Over the first 2 workshops, we looked at data and we challenged ourselves and engaged with people in sharing experience and their challenges. We heard that we have a stretched CAMHS service. By building relationships and a common purpose, we realised if we worked better together, we could reduce duplication and unnecessary workload and achieve more. There were issues along the way, but results do come from that sense of relationship building and the work the team did between workshops made a difference, having that support and ongoing conversations. We have made it an operational programme in how we work together.

EJ stated that she thought it was a really exciting time for the children and young people in West Dorset, but also the whole of Dorset. We have Board Development Session in May, which is mainly focused around children and young people, starting with what good looks like and what

	should we be doing. Also looking at gap analysis and how we engage with agencies across Dorset. This aligns with the ICB objective of healthier children and then adults. It's taken 20 years to change behaviours and culture around children and young people, but this programme is all about communication and relationship building. We come here to deliver the best care we can to our population. If we come back to the fundamentals of Getting it Right First Time (GIRFT) for the most disadvantaged, we on a good route to prioritising what we want to do. There is a lot of passion in teams to get this right, but they also know what improvements to make, and we need to be realistic about that and setting out programme end plan. This will start in to the next phase with the Board Development Session in May. EJ advised that she had already met with Rachel Small and DD and JoH to bring some of that together. We also need some paediatric voices, as we can't do it without them, and from acute and prevention perspective. JoH and team have spot on by saying we need to engage with the children and young people and families themselves. NP added that what we observe as the boundaries are artificial. When we step back and go chatting to patients and families on Kingfisher, asking if they visited Pebble Lodge or other services, as patients are often going between those places and there is work, we can do to make that make sense. NP advised that they had met with a Mental Health and school team this week and they were challenged hard by one of workers around engagement with education. NP was able to talk a bit about transformation, but it starts, and goes back to the wider piece, it that it is not only health or social care involved with patients and how we continue to join gaps and reduce duplication. There is more to do, and we want to be person centred. We need to work at removing artificial boundaries, building compassion and a shared sense of commonality. If there was anything, we can do from education and communications point of view, NP was happy to support that. DCS what really noticeable for him was that we started when he arrived with joint working flagship prgramme and we are now hearing about how it works for children and young people, it's not just what we doing to make it happen it is also the flow of benefits. JoH advised that the Board would see this again at Board Development Session in May. Will flesh out neurodiversity piece and other services delivered in Trust.	
	Resolved: that the Update on Learning from the Children and Young People Flagship be received for assurance.	
BoD24/212	**Finance and Performance Committee Assurance Report**	
Baker Abi 02/04/2025 16:28:00	DU advised the third joint FPC meeting was held Monday 27th Jan. There were no specific escalation items to bring to Board, but FPC did receive a number of assurance reports. In terms of DCH performance, we continue to hear about the intractable issue of no criteria to reside patients and the impacts that has on our day-to-day operations. That is something that has to be addressed with	

system and partners, but it has been persistent for the last 3 4 years and continues to impact operations and finance.

Good news relating to elective care waiting list size and how that decreased and met trajectory over last 2 months. Referral volumes year to date up 6.3% on previous years. Key thing is that activity volumes now achieving more than that level of growth and starting to make traction of bringing down wait times.

Theatres utilisation has improved, and we've moved to the fourth best performance in region, which is worthy of note. DU passed on his thanks to AT and the team.

Cancer care continues to be strong, but demand continues to be high. Growth 10.3% compared to last year but up 45% against 19/20. There are a lot of challenges on performance.

In terms of Finance, we did have another deficit report of £1.6m. We still see significant challenge with our delivery of CIP. There has been good progress back to last year the target £3.4m and we already well before year end achieving £5.3m of bankable CIP delivery and we needed to acknowledge the performance that has been achieved so far.

FPC also heard about the work of Adrian Roberts on the structural deceit review for DCH in 3 particular areas, structural, strategic and operational. Total deficit of £33m. but £11.7 of that really about how the system is set up and that nature of being a West Dorset GDH, Strategic issue £11m and operational challenges we could address £10m. We have to look at ourselves to deliver the operational efficiencies but system partners to address the other two.

National benchmarking noted corporate cost reduced in both Trusts over 5 years. 2 or 3 areas where our benchmark is in the upper quartile of costs and have to focus on those.

FPC received a number of reviews of the Board Assurance Framework, and in Estates and Facilities some scores have been raised.

Finally, assurance reports also received from CPSUG, EPRG and VDB.

FPC approved 2 items. The access arrangement for agency staffing at DCH and the contract award for Southern Counties pathology, but post meeting that now been delayed due to change in specification.

DCS noted that we were putting particular effort in informal meetings, and one will be focussed on the structural deficit review. DCS queried if the informal meetings were a useful time to explore some of these areas.

DU responded that it gives time to explore issues in depth. In the pace of a formal meeting, there is a huge amount to cover, but thanks to the governance teams and operational performance teams we starting to see greater harmony in way we go through reports. and that is bringing a strength to assurance we can gain as we do so.

	CH noted that in part 2 where have more time for colleagues that don't attend Finance and Performance Committee to go in more detail around structural deficit work. In terms of the informal committee in common, it gives us a good opportunity to have a more informal discussion about larger strategic issues. In the next meeting, we have a broader conversation on operational planning in a less formal setting and some broader pieces like support services and function in the Trusts and system. It is a good opportunity for that discussion, but a lot of this will need to be formalised in formal meeting. CH also noted that for clarity, in this, an error in that the decision relating to St Anns in the assurance reports states DCH but it should be DHC. FW added that when we are doing a review of committees, should we review at what is dealt with at informal vs formal meeting. There is a slight risk of potentially business being done in an informal meeting, particularly around DU's area. EJ felt it was a really detailed helpful report, almost as good as being in meeting itself. First question would be is there any insourcing, outstanding we can stop or bring back fully in house to reduce operational costs, and that it was good to see that the structural deficit is outside our control. DU thought that the interaction between selves and others for 2/3s of it. EJ said she gets that somethings that are long term are intractable due to a small Trust's rurality problems and helpful to get Adrian Roberts to start that. Second question is about whether there are any other options relating to off framework and links to the question at the start regarding the uplift and have we got the right establishment for what we do. It is good to see some of the traction regarding CIP, but EJ wondered if we have a realistic plan for 25/26. CH relating to insourcing outsourcing, we know there a proportion of income related to delivering elective activity (ERF). That is now capped at month 8 forecast amount. We are taking a strategic look going into next year, which we will touch on in part 2, there will be a reduction in amount of income received for delivery in activity which means again we need to ensure we completely understand throughput of our own resource and ensure as productive as possible but there may be requirement for insourcing outsourcing to make sure we get VFM. CIP 25/26, we can touch on in part 2 and will form the topic for the next Finance and Performance Committee in Common now in planning for next year. Regarding the on/off framework point, this is something we are working through business planning, and we have had conversations around recognising the heavily restricted financial envelope. JoH added that part of that analysis goes back to what the right number of beds, and that is key to decisions about how we deploy existing resources to make sure we are creating appropriate headroom and that needs to be balanced around any level of investments accordingly.	

	CH continued that we have to have conversations about safe levels for staffing around that too, so triangulation about money and quality. JoH noted that there were clear guidelines relating to reduction of headcount. CL's reflection was thinking about when we come to the review of committees, and we look at the membership and the prime purpose of the committee, as the Chair of QC, she felt her oversight of FPC, whilst the reports were really good, might be something that QC may need to review in relation to the financial impact on quality. Whilst the executive team are very good at having those conversations, it may sometime be better for the NEDs to be closer to those conversations. DU added that the Finance and Performance Committee meeting is triangulating between committees in common, and quality has not been as good as was when single it is something we can solve but need to solve it. JeH wanted to put some caution into the conversation, as she would guard against a position where all NEDs sat on all committees. It is not good governance and reduces the level of discussion and challenge at Board. EJ felt that there should be a clinical NED on the Finance and Performance Committee. NJ added on a similar point, he thought the point relating to outstanding and good around the trade-offs we have to make and how we trade off metrics we are asked to hit. We need triangulated conversation about that as we go through the next few months. DCS felt it was an interesting conversation and that there appeared to be stronger triangulation across activities which he was pleased to see.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD24/213	**Balanced Scorecard (incl. elective tiering)**	
	AT took the report as read. We have increasing areas where we now have targets, e.g. SHMI set target at 1.6 and we are yet to assure ourselves that getting to 1 is something we can deliver. As this review is going to next year against new standards, we agree as part of planning process, when we have the standard for each metric or recognise where SPC charts don't necessarily fit the bill for how we display the details is something that we will work through. Taking performance and recognising already talked about finance and reflective of type of year going into Christmas period for this reporting period. We saw deterioration of the non elective pathway, and it was challenging through December, and we saw that in all standards. It is quite nice to be able to report that we maintained improvement across elective services, but did manage to re-achieve cancer standard. We are leading Trust for 62-day standard and top 5 for FDS. We had an increase in cancer referrals so to be able to deliver that against the pressures we are under is phenomenal.	

	There has been improvement in theatre timings. This area we are yet to prove selves in and that is reflected in way we show assurance in the latter end of the scorecard. Work continues to improve that delivery. We did cross reference with quality and financial standards, and we did see an increase in norovirus in December which meant closing beds and we had increasing pressure at front door. We opened escalation areas, and thanks to the quality team for reviewing to make sure we did maintain quality. This did lead to an Increase in cost and use of staff. NP added that they looked in more detail at the people metrics at PCCI and there was nothing of significant concern. The appraisal rate is not recovering as we would want it to, but all metrics are broadly steady. In part 2 we will be looking at continued reduction of use of temporary staffing which we have already made significant progress in the last 12-18 months, without increasing substantive WTE. The challenge lies ahead but when we look at the current position, we are in a steady state. DCS asked if there was any skill mix variation in those agency moves, and were there any areas where it was difficult to get people. JoH advised that we don't use HCSW from agencies, the skill mix we have is different to DHC, where there is a different plan of supply. Our hardest areas are specialist areas where limited in general access, such as CrCU, SCBU and ED. NP and JoH are working on this. DCH is in a better position than DHC. We have made good progress on temporary staffing relating to mental health input and we have managed to reduce high-cost usage in that area but there is more to do. Whilst we are likely to recruit substantivity to the mental health workforce, it is a a small pool. We need to think about how we use the resources and manage people to work across both Trusts. JoH's only comment was around the norovirus outbreak, which was only one ward, and it was resolved within a week. Across the southwest, we saw high numbers of norovirus. It was hard work for staff at the front door regarding checking and the IPC team were checking. We had high flu rates that peaked in the first week of January, which compromised flow, but teams dis well compared to other orgs across the southwest and they should be commended for that. CH added that the only point he wished to draw to the attention of the Board that was not in the executive summary was the core financial risk to organisation regarding cash. This is driven from financial performance and position. DCS asked if the Finance team were managing that, or whether there was anything the organisation to do to support that. CH said that other than delivering the financial plan, the key driver of the cash risk to the organisation is year to date deficit in £11.8m. We have mitigations in place locally across the system in agreements regarding mitigation of the cash risk this year, but clearly next financial year will be incredibly challenging. We are working across the system around that. It is an organisational risk but also a risk to the Dorset health system and one	

	thing we are ensuring is in place in planning is the cash principle to make sure DCH viable from a cash perspective going forward. We are making sure we do everything we can to deliver the financial plan and VFM for income into organisation.	
	Resolved: that the Balanced Scorecard (incl. elective tiering) be received for assurance.	
BoD24/214	**Finance Report**	
	CH advised he would take the report as read but he would highlight the key metrics and points to note. • Month nine delivered a deficit of £1.6 million after technical adjustments, being £2.5 million away from plan of £0.9 million surplus. • The year-to-date position is £7.3 million away from the reported plan standing at an actual deficit of £11.8 million. • We are broadly in line with the revised trajectory with agreement from the system relating to the system delivering adverse position of £25m. • In terms of the key drivers of financial position, these are continuation to large degree of those discussions already held in Finance and Performance Committee and Board. These include inflationary pressure above the budgetary assumptions in planning, including significant pressure in drug expenditure during the year to date. This is not unique to DCH, but we anticipate in the region of a £6m overspend on drug budget for year which significant. A lot of work internally is being undertaken on this, as well as working across the system and wider NHS to ensure really good understanding of the level of expenditure and the mitigations. • Pressure of escalation beds and no criteria to reside patients remain a cost pressure. 18 escalation beds in month. These are broadly unfunded beds so above the level of income we receive. • Agency spend has continued to remain low. • CIP scheme stands at £14.4m (5%). We have delivered £5.2m (35%) however we remain behind plan by £3.9m. We are anticipating a full year delivery £8m this year, which is just over half. Obviously, that in line with planning assumption and the Finance team are routinely challenging through organisational divisional meetings and Value Delivery Board to ensure we end in the best place we can. • Current cash position of £3.7m. It is worth noting however we have been putting in monthly revenue support requests and just found out February request has been declined. That is now 3 declines. It is not unique to DCH, CH and MBr are working on this with ICB and system. • Capital is behind plan by £1.5m however in reality we generally see significant uptick in last quarter of the year. We have a risk of overspend in region of 1.5m but have mitigation place to come in line with plan. DCS queried the spend on the drug cost and asked if it was price inflation or volume of use. CH advised it was both. DCS asked with the price inflation whether we were buying as a group or whether it was a national	

	thing. CH confirmed this was a national issue and it was not unique to DCH. Nick Jones undertaking a lot of work with his team ensuring that we are switching to the most cost effective and generic drugs where we can. They also have all the detail of who is prescribing the medication. In reality due to operational pressures and increasing productivity we are increasing the volume of drugs we are using. However, we need to ensure that we are only prescribing as required and cost control is important from that point of view too. NJ advised that on the drug usage and cost issue, an analysis would be going to a future Finance and Performance Committee, that understanding of unit versus volume and prescribers would be helpful. NJ felt assured that CH and the team were monitoring this on a daily basis. In terms of the cash, NJ raised a query on whether there was a risk that we get to point where can't recover it and whether we have a break glass moment on our cash position. CH confirmed that we know what our working capital balance is and where we need to be as a minimum on a daily basis. Routine cash monitoring is in place. Mitigations and agreement is in place across system for this year. but technically we only have 1.5 months left. Operational planning has fundamentally been agreed for cash agreements. The restricted cash position nothing new, there is wider reserved balance across system and ii suspect that is a key driver as to why we don't have national acceptance regarding additional cash in Dorset, but it is not unique to Dorset. SP commented that the break glass for him was that we can't afford to pay staff, this could not be allowed to happen. On p142 of the papers, if we look at substantive spend on year-to-date basis there is a 14m overspend, also we have 18/19m worth on revenue income. SP asked how assured that overspend of substantive is matched by income and how much isn't', at face value we have more heads than planned for. CH this is the broader transformation to workforce. The vacancy rate has significantly reduced over year 18 months so there has been an increase in substantive costs. If we look through to agency usage that has reduced significantly over a period of time too. Operationally impact and metrics are key in that. NP noted that the costs had gone up as we have reduced vacancy rate, and reviewed establishment need and safer staffing. We could go on about productivity which is not where want to be right now, but we need to keep focused on quality SP asked if we budget for agency. CH confirmed that we don't have an agency budget, NP clarified that vacancy money is paying for agency cost. JoH explained that our headroom is not covering planned absences, so that is what is driving is deficit in ward budget. SP queried why substantive was over budget, we must have more head than budgeted for, unless we have brought more heads in. EJ asked how much of that was related to salary increases or are staff costing more than they should. CH said that this is an incredibly complex situation recognising the WTE ask and something for planning next year, if we can	

	pick that up through operational planning that be key. We have triangulated budgets through this and things like the pay uplift is actioned on an annual basis and can be tracked to overall budget. When driving the establishment work, we then have ward headroom as JoH is talking about which funds things like sickness etc, it gets muddy but we do triangulate through budget setting. NP added that we track this through the vacancy control panel weekly and at Executive meeting. At DHC, we made reductions in agency spend, we also haven't got to WTE number by end of year, but we have overall financial envelope so where we've focused on WTE, we have proxy measures which get us to the clinical outcome we need to achieve. DCS noted an action for board to hear back re SP point.	**CH**
	Resolved: that the Finance Report be received for assurance.	
BoD24/215	**People and Culture Committee Assurance Report**	
	FW noted an error on the report in terms of the Chair and Exec Lead names and apologised that this had not been picked up when reviewed. This would be amended. Report was taken as read and there were a few highlights to flag. There were no specific escalation items for board. Key highlights were the workforce KPI dashboard, the reduction in agency spend and the improvement in essential skills compliance. Vacancy turnover rates and linking work between the two trusts and the contract costs relating to occupational health were reducing. Regarding the EDS2, there was a plan within the consent items. PCCiC looked at toolkit and both the DCH and DHC assessment outcomes were 'developing' but the item was well discussed, the action plans were there and over time we will see the developing picture, so assurance provided to the Board that work was in hand. The Committee received an update on the Sexual Safety charter and policy implications. EJ and FW would like this to be triangulated with NHSE and collaborative action plan across both Trust's and focus going forward working together aligning reporting and assessment approaches and we are beginning to see the benefits of that. On the Board Assurance Framework, PCC have two risks, SR2 Culture and SR3 Workforce. There were no changes in scores with a small number of overdue actions and revised plans in place. Nothing leapt off page as concern. Noted in terms of Corporate Risk Register plans to align reporting approach across the Trust and DCH reported no new high scoring 20+ risks. One decision was made which was the approval of the EDSD2 action plan. There was one referral to another Committee which related to digital to be	

	referred to the Strategy, Transformation and Partnership Committee in Common. MBI advised that she had some minor issues to raise under EDS reporting but would pick this upon the agenda item. Consent item. MBI wondered whether the Trust had undertaken any external validation on our ratings, and whether there was any value in doing so, as to a degree we are marking our own homework, so an external view would give an indication as to whether our ratings were accurate or if they had any internal bias. NP responded that part of the methodology of EDS2 does include degree of internal feedback and engagement to ID scores with some partners and stakeholders. Some of that information was drawn from the staff survey. Another anonymous survey took place in January and the results were taken to a further workshop. JoH added that for domain 1, three services had gone through and external panel within UHD, DHC and NHSD, so validated externally collectively. Various methods are applied throughout. NP continued that it was a good question, and we would aspire to do more. The process can be come unwieldly but, on that aspect, we did want to do far more. People attended different forums, and they all had the opportunity to look at ratings and say if they agreed or not. DU raised a different topic and asked NP about where the Trust was heading in regard to the WTE reduction to return to March 2023 levels and we are 110 away from that at the moment. NP responded that at month 9, we were 7 WTE behind our forecast position. We are ahead of forecast substantive but behind on bank, and ahead on agency. The headlines would be that we have good agency reduction, bank not moving and substantive creeping up. There is a big growth in substantive relating to newly qualified staff in September and that was reflected in all Trusts in the system. We revised our position to try to get something that more realistic and achievable where we were and on month 9 data, we needed to get to 110 WTE to get to our forecast. What we have then done is put together a list of immediate actions to get closer to that target and those actions are RAG rated, including fixed term contracts, internal adverts first, MARS scheme, further reductions in all divisions and then also reductions in temporary staffing. That is being overseen by a weekly internal recovery group, which includes NP, NJ and CH, looking closely at the actions and plan. NP wouldn't want to put a number on where get to at year end. The MARS scheme has not had numbers of applicants that we had anticipated, but what we have seen are reductions in divisions, in a planned and safe way, that are being fully QI assessed. We have not seen the reduction in bank usage. We need to take the full report to the People and Culture Committee in Common at end of year or as part of discussion for next year, when we have that	

	picture of how things have moved over time and the impact of those bridging schemes. FW in terms of informal meetings, we are flagging up what we plan to do next. We are going to look at the joint People plan and start to get some informal shape into that, as well as visiting a service. EJ suggested that the detail went to the next People and Culture Committee in Common but wondered from the triangulation if we should get assurance about QIAs in Quality Committee, particularly as we get into more detail about making riskier decisions. NP responded that absolutely we could, but we could also talk through where RAG ratings are to get to year end. We had intended to have at more discussion at the People and Culture Committee in Common but time got away.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD24/216	**Strategy, Transformation and Partnership Committee Assurance Report**	
	DCS reported the matters to be raised fell around digital capability and capacity, and whether we have capacity to undertake what needs to be actioned. In March 2025, STP are planning to look at the overall programme, and what the team can manage to achieve. Plan is to question the tasks that we ought to do need to be purposefully selected, so it aligns to the way the strategy moves forward. The Committee took the view that this alignment needs to be undertaken to make sure we are not moving forward on every strategic issue and partially completing them but pushing and completing the ones we really want to. One of the things that NJ and DCS are keen to start drawing out the benefits of the work undertaken, and that was something that was demonstrated earlier with the children and young people presentation. It was also a great presentation from the neonatal team in benefits of adopting a culture of continuous improvement. It's around behaviour, support and cultures. STP agreed that the frailty programmes should be moved to the UEC programme of work. This was one of the first flagships and has now moved into that area. INT proposal for our approach was aligned with national policy. There are two lots of funding of about £2m, sought from ICS not from Trust so not additional cost. It went to the SEG and was approved. NJ confirmed this was approved and it now goes on to ICB committees and Board. STP approved the recommendation made in the Quality Committee that they should consider whether the GOSW should be reporting to Quality Committee or to People and Culture Committee and that needed to be worked through. AH felt that it probably would feed in, so it probably would not matter but AH felt it sat better with quality. JeH advised that she did not have a strong view, and that DHC Quality Committee and they	

	agreed should stay with the People and Culture Committee in Common. JeH advised that we will undertake a review of all TORs and move if needed. JoH added that in Quality Committee we report safe staffing via quality metrics, and that she was happy to look at breaches to see if they triangulate and look at the metrics for safe working and safe staffing and whether this aligns to more common incidence of harm. DCS queried if we are recommending that it goes to the joint Quality Committee, so that we have one approach. JoH advised that it was part of the discussion at Quality Committee and there was already a lot of work going in to redesigning that committee into a Committee in common. DCS final point to raise, was the approval of the recommendation to move to a joint Quality Committee in Common and there now process before that is finally signed off, including the TOR etc. JoH advised that a group had been setup looking at this across both Trusts. The proposal is to implement in 25/26, so the first formal meeting would be in May, and we could have an informal meeting in April. TOR will come through in March and then to Board in April, but support at SPTCIC is required to enable both QCs to take next step. DCS said it would be good to use the informal meeting in April for people to meet and go through the TOR so that the Committee would be able to hit ground running in May. CL asked that we also formally minute we are also reviewing the position regarding the QCIC if it transpires that it is not working and we are not able to get the assurance required there, to flexibly review arrangements. This had been discussed in Quality Committee. DCS advised that he was sure that there was that with all committees, but we need to be clear that a lot of work gone in to underpinning Committees in Common, so that it was worth working through that. JeH added that they are not joint committees, they committees meeting together and that they could meet separately or together. EJ noted that QC would continue as they are until April.	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD24/217	**Joint Strategy Implementation Update**	
Baker,Abi 02/04/2025 16:28:00	NJ introduced PL to present the highlights from the report to leave time for questions and feedback. PL advised that the Strategy was approved 5 months ago, and since then we have been busy implementing it. This update provides assurance that we are making progress against the plan. There are risks but we understand what these are, and they are being managed, and appropriate oversight is in place to keep track on what is happening.	

We wanted to make sure it is not just a document but that it focused on implementation and there are 4 components to that.

These are the:

- Culture, Communications and Engagement (CCE) plan,
  This will bring the strategy to life and support staff to understand the impact of the strategy on them in their roles and how they can assist the federation with implementation.
- One Transformation Approach (OTA),
  This is in implementation and consists of 4 portfolios:
  - Place & Neighbourhoods – Integrated Neighbourhoods Teams and Frailty
  - Mental Health – Access Wellbeing and CYP Mental Health
  - Sustainability – Our Dorset Provider Collaborative
  - Work Together – implementation of this strategy, Electronic Health Record, Support Services review and New Hospital Programme
- Joint Improvement Framework (JIF),
  This aims to build on existing good work and support the Federation to become a recognised improving organisation, inspiring, empowering and enabling our staff and people and partners to improve in ways meaningful to them.
- Enabling Plans
  These are in development and are looking to be approved in March 2025. These plans are built on the joint strategy and detail added to enable staff to understand the changes that are required. There are 4 plans:
  - Clinical and Quality
  - Digital
  - People
  - Finance and Infrastructure

There is a lot going on and there in a comprehensive implementation package. To track we are actually making a difference, we are developing a joint strategy dashboard. Good progress is being made, and we are close to finalising the dashboard. The report also includes a Strategy Roadmap, and this covers where we are going and details the progress made since starting the journey in September 2023.

One of the key risks is the federation's capacity to transform, and we have to get down to priorities we can manage. PL stated that he was pleased to present to the committees in common with revised set of priorities. The second risk relates to staff engagement particularly around the enabling plans. Operational pressure and volume of work means the team are not as far along as with fleshing out the enabling plans they would wish to be. A clinical leadership group is now in place and that mitigates some of the risk, as there is engagement, but this continues to be a risk. In terms of the oversight working group JTIB and Strategy, Transformation and Partnership Committee in Common are in place now.

The main focus for the strategy so far is about process and structure and that is not unusual at this point for a single trust or federation. We are unlikely to see any pay off from those transformation programmes within the first five months. Case studies will be brought to the committees in

common and Board so that they are able to see the difference that is being made to staff and patients.

DCS agreed with that point and added that it would be great if we had a residents benefit roadmap so we could see the accumulating benefits that our benefits and residents achieving.

NJ agreed that there was something about correlation and causation with all the things we are doing. The strategy dashboard is what we are building to be provide that information, and, in parallel, as seen earlier with children and young people presentation at committee in common, we had colleagues from SCBU talking about their improvement approach as well. We are trying to make sure we are bringing people to talk about changes they are making off the back of the strategy to create 'strategy in action' case studies. Unsure whether we can get this into a benefits roadmap, but we will look at how we might do this.

MBI noted that there was a lot of focus on structure, process and opinion and we needed to see something further down the line that is measurable to determine the impact on staff and patients. MBI felt she had that assurance from the conversation. However, when we look at the ambition strategic goals columns, they don't show the outcomes and MBI wondered if the breakthrough objective column, whilst it was still largely targets rather than current impact, whether that needed to have more measurable targets and progress rather than 'improve more of'.

We should be seeing more measurable outcomes. MBI questioned whether we needed to integrate within breakthrough objectives something that shows current progress rather than strategy, we shouldn't just say we will improve but does not state by how much or by when. We need to more clearly identify where we are and where we are going to be.

PL advised that the idea was that we wanted to get agreement on what we measure to make sure we got that right, so we encompassed all things that we wanted to achieve from a strategic perspective but keep it to a few. That has been a challenging exercise, but we are through that now. The next steps are to quantify. We need to make sure we have metrics for all things we want to measure. Some we do have already, but some we don't as we are trying to change the direction of the federation. We need to understand current performance and once have that we will be better informed to set ambition targets. The proposed process will go through committee in common to agree.

EJ added that she thought the roadmap was useful as is the emerging dashboard. Following on from MBI's comment, EJ thought the what we've got, the how and when detail will come over time. EJ questioned some of the language, as English was not EJ's first language, reading the document EJ became confused. For example, are components, portfolios, delivery initiatives, the same things or are they different. EJ commented that if she was confused when she knew about the strategy, what would it mean to frontline staff particularly those that have joined us from abroad. EJ wondered if a refresh, not just plain English, would assist so that we all have the same understanding of what it means, and we are all using the same language to assist with engagement. PL thanked EJ for her

	feedback and acknowledged that he could back himself up in language and it was a good reminder that not everyone was in the same space. DU wished to commend the next steps in Strategy, Transformation and Partnership Committee in Common in looking at the work of the federation and prioritising to make sure we have the right things, but we need to include in there the work for the PPC and potential programmes like EPR. We will have severe financial strictures and only limited capacity to deflect clinicians from any jobs and creating space to think about transforming how we do our work. DU noted that with the current levels of engagement, we could not cover all bases. We need to take a SMART look approach, we need to commend work, but we also need to look wider than just the Federation. DCS added that when we look at the capacity view, there also needs to be a lens of clinical capacity. NJ felt that the conversation was helpful. We set the whole structure up and appreciate EJ's comments on the complexity about how things fit together. We set the structure up as recognised that we were trying to do too much, we are not strategically aligned, and we do not have capacity to do everything. That is not just transformation resource, but the capacity of the organisation. People may remember that we have been through one prioritisation process, but we are now in a place where need to do that again. It is a constant evolving thing, but as we go into 25/26 we need to be clear on what priority areas are, and recognise that we doing that in context of finances. We have been hindered in implementing some things we want to do this year as we have not been able to recruit to TMO lead to demonstrate the outcomes. We need to think about how we are deploying constrained resources, noting that it is a difficult decision about what we deprioritise. What we are trying to do, is to make sure we have a structure in place to be able to manage that process and recognise people's frustration that we are still talking about process structures, but we are just in that part of cycle where getting set up but we are really mindful of what we need to do to demonstrate that we are making differences.	
	Resolved: that the Joint Strategy Implementation Update be received for assurance.	
BoD24/218	**Audit Committee Assurance report**	
Baker Abi 02/04/2025 16:28:00	SP advised Board that there had been two meetings to report. First meeting was 17th December 2024, SOD was retrospectively approved by The Board. The Audit Committee was ok with the minor amendments to SOD. Second point SP wished to raise was the Internal Audit report on their system governance report. That remains still inconclusive. DCH flagged that they were not happy with ICB responses, and same came from DHC. As at February 2025's Audit Committee, those issues were not concluded. Internal Audit are continuing to push back on that. SP was unsure of the leverage we have if the ICB are not responding to the report	

	comments, and neither organisation is happy with lack of responses. DCS felt it would be worth talking to MBr re ICB. SP advised that in terms of highlights, there were a few to bring to the attention of the Board. Internal Audit had agreed MIS was in good order, and at that stage advised that they were confident they had seen enough evidence to give full compliance, which had since been confirmed. In regard to the DPST, there was a slight change to this year's submissions. Previously, it was all mandatory, but now it includes a selection process. We can choose 4 categories in a certain area. SP stated that he had asked IA to run the selections past DU, utilising his expertise in that area. DU confirmed that he had received that invitation. SP moved on to the report from the February meeting. The Committee noted the good work in the development of Board Assurance Framework and first two points relating to digital (SR6). It was noted that the risk had been increased to 16. The Committee had also noted the enforcement notice from the ICO and will respond accordingly. SP reported that a few items had been referred to other Committees. Audit Committee had requested that the cultural maturity audit be passed to PCCIC for oversight, so they can make comment, but the report was generally favourable. A recommendation was made that the Mental Health Act compliance report should be shared with Quality Committee. One key issue was discussions with External Audit around what the next year audits will be. Cash will be one as it remains an ongoing concern. The draft plan will be discussed at the next meeting to finalise. Identified areas of risk were: • Revaluation of Land and Buildings (risk of error) – The work being undertaken does not appear to place us at a greater risk than previous year. • Completeness of expenditure and year end accruals (risk of fraud) – there is an increased likelihood of risk, so this will be monitored. • Management override of controls (risk of fraud) – this reflects the pressure any financial team might come under to manipulate and there is a heightened risk of management override of controls.	
	Resolved: that the Audit Committee Assurance report be received for assurance.	
BoD24/219	**Scheme of Delegation**	
Baker Abi 02/04/2025 16:28:00	CH said this had already been referred to in the Audit Committee in their December update. The Board had approved the revised SFIs and SODs in at the December board meeting. However, there were a few updates made to this document following that approval, which are detailed in the Executive summary. fa f ew wording and also there 1 error in terms of authorisation of non pay expenditure sign off to be updated as well. This is being brought back to Board to sign off those updates. The Board approved the scheme of delegation.	

	Resolved: that the Scheme of Delegation be received for approval.	
BoD24/220	**Freedom of Information Requests Compliance and Service of Enforcement Notice from Information Commissioners Officer**	
	NJ reminded the Board about the discussion of the accumulated DCH backlog of FOI requests, and that we had escalated this, and informed the ICO of the position and the plan we had put in place to address this. NJ expressed his thanks to JeH for support around resolving these issues. The plan was to link up the DCH FOI requests with the DHC FOI Team, and staff were recruited, on a fixed term basis to support this. NJ was pleased to report that, as at today, that backlog was down to around 24 requests. However, not unexpectedly, we have now received an enforcement notice from the ICO, which is the lowest level of action they can take. They have been reassured by the engagement of the DHC FOI team, and the transparent and open approach we took with them. We are in a relatively good position from where we were. We do need to respond to the ICO letter, and this has been drafted, subject to any comments from the Board today which we will feed into the response, which MBr will sign as ICO wrote to him. DCS thanked NJ for the update and thanked the team for their huge effort in getting through backlog as almost there. EJ noted that this was a concern for us and that it was important not to underplay it. A backlog of over 1000 is significant. We need to look at this from a learning perspective and see what we can apply to any other similar issues particularly as things get tighter. EJ said she was not sure the plan resolved the longer-term issue, as we were relying on the good will of DHC to support this and there will always will be FOI requests and having read the letter from ICO questioned whether we are now publishing timeliness statistics and using the plans ICO recommended as if we don't do that it's a home goal. SP stated that asked that question specifically at Audit Committee as to whether we were now using the self-assessment toolkit and that he was awaiting a response. JeH commented on the point around the long-term plan. We are not relying on the good will of the DHC team, additional fixed term staff had been brought in to the team to assist in clearing the DCH backlog, and that there was a formal SLA arrangement in place for DHC to provide that service, which was the long-term plan. It was note that regular reports would be submitted to the relevant Committee. NJ will respond to the ICO letter within their deadline	
Baker,Abi 02/04/2025 16:28:00	**Resolved: that the Freedom of Information Requests Compliance and Service of Enforcement Notice from Information Commissioners Officer be received for information.**	
BoD24/221	**Charitable Funds Committee Assurance Report**	

	DU advised the Board that the Charitable Funds Committee had met on 20th January 2025. There was one issue for escalation to the Board, who were acting as the Corporate Trustees, that will be considered after part 2 of the Board meeting, which is the 2025/26 charity business plan. This had already been received and approved at the Charitable Funds Committee. DU informed the Board that there had been a little debate between their meeting and now in terms of a proposal regarding vision and mission statements for the charity, but DU reported that they were close to getting agreement. DCS asked DU to confirm that there was no change to the charitable purpose. DU confirmed no change, and in terms of the actual issues discussed there was only one short report. In terms of the Lilian Martin legacy, which longest standing agenda item, we are moving towards the final stage. There are 6 beneficiary charities involved in this legacy, and it pertains to land across Kent. Wessex Water have been renting part of this land but have not been paying the rental costs to the beneficiaries. We have sent them notice to quit and given processing plan it difficult to comply. Wessex Water had offered £190,000 3 years ago, but nothing about proceeding. Agreed a purchase price of £250,000 to be concluded by the end of this financial year. The Charitable Funds Committee are approving that price as one of the 6 charities. It will leave us with another piece of land and hopefully, in future, the use of grey belt land might have further value. This could be the start of conclusion of long-standing agenda item. DCS well done sorting that out and commented that there may be a big increase in value.	
	Resolved: that the Charitable Funds Committee Assurance Report be received for assurance.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD24/222	**ICB Board Report**	
	Resolved: that the ICB Board Report t be received for information.	
BoD24/223	**Equality Delivery System 2 (EDS2)**	
	Resolved: that the Equality Delivery System 2 (EDS2) be received for assurance.	
BoD24/224	**Questions from the Public**	
	KH asked how a patient should go about getting a second opinion or making use of Martha's Law.	

	JoH explained to the Board that Martha's rule is an initiative driven by the parents of Martha who was 13 years old, who deteriorated in a London hospital where there was a failure to recognise sepsis and a failure of the team to seek fresh eyes' view. Martha's mum lobbied the DoH and Government to implement a mechanism by which a patient or family member could call for help to get a fresh eyes review and second opinion. NHSE launched the Martha's Law initiative and DCH were successful in bidding to be part of the wave 1 implementation. We are now live with Martha's rule, which is sometimes called a 'call for concern'. In reality, that enables a patient and/or family to call a dedicated phone number to ask for the critical care outreach team to give a fresh eyes review. This is safety netting clinicians who may have developed diagnostic bias, or that maybe not be seeing the signs of deterioration if involved in care over time. We were already doing that in maternity services. We have been submitting data for last 3 months and have been averaging around 2 calls a month. We have been seeing those calls come through but at number we anticipated were manageable. We have asked for an assurance report to be presented at the Quality Governance Group to pick up any themes or learning, or anything we can do around future communications. This is not a second opinion as under the NHS constitution patients can already seek opinion. This is more a review by a second clinical team. Second opinions are often sought in an outpatient setting or regarding a diagnosis or treatment plan. DCS and the thing about asking for second opinion was a certain nervousness about how go about that without upsetting people and might be AH or JoH a little what should KH say to public how do that without upsetting anyone. AH responded that in a ward setting, a request could be handled through the ward nursing team or the senior nurse on the ward. It would be impossible to say no one be upset, but in reality, the vast majority of clinicians would not be concerned at someone asking for second opinion. It is something that happens regularly. KH advised that she thought that the comment regarding Martha's rule was a red herring as she was asking about gaining a second opinion and appreciate that a few people may be upset. She thought that it was more around how a patient or relative could request a second opinion, realising that there would be some nervousness around this, with people not wanting to upset or offend anyone by requesting a second opinion. They are effectively challenging the people giving them, or their loved one, care. The question was more around, how they go about asking for that second opinion, without having to ask the person who's opinion was being challenged. AH said that was a difficult question to answer, as it does depend on the relationship between the patient and clinicians. Sometimes someone will be upset, but a second opinion is enshrined in NHS, and for AH he felt that it was not part of everyday practice, but it is regular practice, and a sensible doctor or senior nurse will not infrequently ask for a second	

	opinion themselves if they are not quite sure. It's difficult to give hard fast advise trying to do it without telling the team who are looking after you, it can be very difficult and slightly risky, as you can have two streams of thought about how people should be looked after, but it has to be brought to the attention of team looking after the patient because needs to be facilitated. DCS summarised that it sounded as if, in a hospital setting that the most likely route would be through the senior nursing team rather than directly to the doctor. JPL raised a question about the financial situation and noted that some of the results are coming from incorrect assumptions, some of which are imposed on DCH, namely growth in emergency attendance. JPL would be interested in the technical paper looking at structural deficit and thinking this technical paper is dry and whether we use it as a lobbying paper that could be transformed for a target audience e.g. MPs etc. and methodology should be replicated in other hospitals to be transparent and benchmarking. On other hand can only make points on that if deliver on productivity, need our credibility to be able to push for structural deficiency. DCS advised that the paper itself was in part 2, so it would not be discussed here, but the comments were right and as DU had said there was a three-way balance across three areas. DCS thanked JPL for his question and noted that it would not be discussed in more depth at this point.	
BoD24/225	**Any Other Business**	
	DCS thanked AH as this was his last public Board meeting. DCS stated that AH had bought amazing skill, maturity, patience reassurance and all the things that we expect from an experienced and very good medical director and that we were really grateful for that. DCS noted that there would be many occasions to say thank you, but on behalf of Board DCS wished to thank AH for his contribution to the Trust.	
BoD24/226	**Resolution Regarding Press, Public and Others**	
	To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.	
BoD24/227	**Date and Time of Next Meeting**	
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **9.30am** on **Tuesday 8th April 2025** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**	

BoD Action Tracker, Part 1 - 2025/26

Minute Reference & Name	Date of Meeting	Topic	Action	Lead	Deadline	Response	Status
BoD24/214 / Finance Report	11.02.2025	Substantive Staff	Further detail to be provided on why the trust was overbudget on substantive staff.	CH	08.04.2025	Verbal update to be provided in the meeting	Open - Due
BoD24/164 / Guardian of Safe Working Report	10.12.2024	Impacts of Escalation Reports	DD AH to look in to any potential quality impacts of the escalation reports raised by resident doctors, and whether it was possible to triangulate with risk data.	DD ~~AH~~/RW	08.04.2025	Update awaited	Open - Due

Actions to other Committees

Minute Reference & Name	Date of Meeting	Topic	Action	Lead	Deadline	Response	Status	Committee referred to
BoD24/151/ Matters Arising: Action Log	10.12.2024	Acute Hospital at Home Service	Further detail about the Acute Hospital at Home Service to be returned to Quality Committee.	QC	28.02.2025	Referred to Quality Committee and on the February agenda. Acute Hospital at Home Service Assurance Report was considered by Quality Committee last month (Feb). The agreement was that this would now report annually, unless emerging risks or issues require escalation.	Complete	Quality
BoD24/154/ Quality Committee Assurance Report	10.12.2024	Digital Teams Update	Strategy, Transformation and Partnership Committee in Common to receive an update on the capacity, bandwidth, and priorities for the digital teams	STPCIC	28.02.2025	Complete. Item presented to the January Strategy, Transformation and Partnership Committee in Common	Complete	STP
BoD24/156/ Learning from Deaths Report Q2	10.12.2024	Potential mis-triage to the Ward	Further assurance around the 'potential mis-triage to the ward' indicator detailed on page 67 of the papers to be provided to the Quality Committee.	~~AH~~ / RW	31.03.2025	Update awaited	Open - Due	Quality
BoD24/100/ CEO Update	09.10.2024	Ridgeway Ward Redesign	An investment review of the ridgeway ward redesign to be returned to Board.	CH	12.08.2025	The review of ridgeway ward would be returned to Board once it has been reported to Finance and Performance Committee.	Open - Not yet due	FPC

Dorset County Hospital
Dorset HealthCare

Report to	DCH and DHC Board of Directors	
Date of Meeting	DCH – 08 April 2025 / DHC 09 April 2025	
Report Title	Chief Executive Officers Report	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety; SR2 Culture; SR4 Capacity and Demand; SR5 Estates; SR6 Finance; SR7 Collaboration, SR8 Transformation and Improvement	
Financial	No specific implications arising from the report – update on mid-year (H2) position	
Statutory & Regulatory	Update on EDS2 and Public Sector Equality Duty	
Equality, Diversity & Inclusion	Update on EDS2 submissions	
Co-production & Partnership	Update on system working	

Executive Summary

This report provides and overview of key national and local developments:

- National changes to the NHS and Department for Health and Social Care
- NHS Performance Assessment Framework
- Board Member Appraisal Guidance
- Board to Board to Board (DCH / DHC / UHD)
- Provider Collaborative
- Development of Joint Strategy Enabling Plans
- Operational and Financial Plan
- Staff Survey
- Board Changes
- New solar panel funding awarded to Dorset HealthCare
- Funding to support green spaces on hospital site
- Emergency Department entrance move

Recommendation

Members are requested to receive the report for information.

Chief Executive Officer's Report – April 2025

1 National updates

1.1 National changes to the NHS and Department for Health and Social Care

National announcements last month set out plans to abolish NHS England, with many of its functions being absorbed into the Department for Health and Social Care. A new national leadership team will set out an approach to transition to the new arrangements. Elizabeth O'Mahoney, who has been the NHSE Southwest Regional Director has been appointed Chief Financial Officer in the NHSE transformation executive team, working to newly-appointed Chief Executive Sir James Mackey. Sue Doheny who was the Chief Nursing Officer in the Southwest region will become interim Regional Director.

Closer to home, Integrated Care Boards been told to reduce their costs by 50% and this will be a significant challenge. NHS trusts are also required to reduce the costs of their corporate services and explore more efficient and cost-effective ways to operate, include the possibility of subsidiary companies.

On 2 April 2024 in a letter to ICB and Provider Chief Executives and Chairs the NHSE CEO provided some further clarity on plans for the coming months. This included 2025/26 planning submissions and the ongoing review of delivery confidence as part of the process to finalise plans; the intention to shift towards a medium term approach to planning; the need for strong Board accountability; future role of Integrated Care Boards (ICB's) and the collective challenge in managing the transition; request for all NHS providers to reduce their corporate cost growth by 50% during Quarter 3 of 25/26; an adjusted approval process for subsidiary transactions with guidance to be issued shortly; imminent publication of the response to the NHS Standard Contract consultation and payment rules consultation for 25/26; publication of the 25/26 NHS Performance Assessment Framework (further details below) and; Urgent and Emergency Care Delivery Plan publication. Full details can be found at: NHS England » Working together in 2025/26 to lay the foundations for reform

The changes are focussed on ensuring that our limited resources are directed as much as possible towards patient care, recognising that the NHS does not have the resources to continue delivering services in the way it has been up to now.

The increases in demand, cost of providing healthcare and the national economic picture, mean that we are going to have to take radical steps in redesigning care. We are already working to change models of care and work more efficiently, aligned with the government's three big shifts –treatment to prevention; hospitals to community; analogue to digital. We will learn more about this, when the 10-year plan for health is published later in the spring.

In the meantime, a huge amount of work has already happened in our teams to respond to the ask for efficiencies and savings, with some significant programmes underway. These include the way we manage urgent and emergency care, developing community-based healthcare, making the best use of our estate and looking at the way corporate services are run.

Our federation arrangements are a great foundation for some of that work, alongside work through the Our Dorset Provider Collaborative with wider partners such as University Hospitals Dorset.

This will be a significant challenge, and we will ensure that we have the right support in place for colleagues as we move through the changes to come.

1.2 NHS Performance Assessment Framework

A revised regulatory oversight framework for 2025/26 was approved for consultation by NHS England's (NHSE's) board at the end of March 2025. NHS England » The NHS Performance Assessment Framework for 2025/26. This will go out for testing and engagement in April followed by a short period of consultation in May 2025. It is scheduled to be published at the end of Q1 with the first segmentation of trusts and ICBs happening in July. The draft framework sets out:

- Clearer roles and responsibilities for NHSE, ICBs and providers
- How segmentation will be assessed
- How good performance will be incentivised and rewarded
- The set of metrics against which trusts and ICBs will be assessed, which include those related to the NHS planning guidance for 2025/26 together with other measures related to finance and productivity, public health and patient outcomes, quality and inequalities, and system working.

The draft framework sets out proposals for a new approach to provider segmentation decisions and delivery scores. Any trust in deficit will be restricted to a maximum segment score of 3 (where 1 is the high performing and 4 is the poorest performance). A separate segment 5 has been created for trusts in segment 4 whose capability and other factors mean they should enter the Recovery Support Programme.

1.3 Board Member Appraisal Guidance

On 1 April 2025 NHSE published updated guidance on Board Member Appraisal NHS England » Board member appraisal guidance. This guidance outlines NHS England's expectations and recommendations in the completion of board member appraisals. It has been developed to support board effectiveness and to ensure a consistent and standard approach to appraisal, recognising that there will be a requirement to adapt depending on the type of organisation and whether the appraisee is an executive or non-executive director. At DCH and DHC we adopted the Leadership Competency Framework for 24/25 appraisals (including multi-source assessment feedback) and we will consider any further updates required to ensure the new guidance is implemented.

2 Dorset Updates

2.1 Board to Board to Board (DCH / DHC / UHD)

On 14 March 2025 a three-way board meeting was held with board members from all three providers within the Dorset system attending to discuss the future ways of working collaboratively within the Dorset system. It was the second time that the boards of all three providers had met in this way, and we were able to discuss together our shared goals to improve healthcare for our population and how we might make best use of our collective resources to help improve the delivery of healthcare in Dorset.

We used this as an opportunity to take Board members through proposals to create a wholly owned subsidiary across our federation and with University Hospitals Dorset (UHD). We are developing a business case for our Boards to consider prior to submitting to the NHSE approval process.

We have recently decided to appoint a Joint Chief Digital Officer across DCH, DHC and UHD. Beverley Bryant, who has been appointed to this position, shared some of the challenges and work programmes at this meeting.

A follow up meeting is to be arranged during June.

2.2 Provider Collaborative

The Our Dorset Provider Collaborative (ODPC) Board met on the 19 March 2025. The key areas of discussion were related to Dorset Digital Services; Pathology; CDC; strategic framework. The ODPC members also reflected on the 3-way board session held on 14 March 2025 and the proposed priority programmes. It was recognised by the board that resources would be required for the successful delivery proposed priorities.

2.3 Development of Joint Strategy Enabling Plans

Following the agreement for DCH and DHC to become federated organisations, planning began to develop a Joint Strategy which would set clear, joint strategic objectives for the trusts to deliver. The Joint Strategy was published in September 2024, which prompted the requirement for a number of enabling plans to bridge the gap between the strategy and delivery, across five key areas:

- Clinical and Quality
- People
- Finance
- Infrastructure Plan
- Digital

The five plans have been developed in collaboration to avoid siloed planning, support engagement efforts, and to gain an understanding of how each plan will contribute to supporting the strategic objectives.

In line with discussion to move to a Joint Chief Digital Officer across DCH, DHC and UHD, the remit for the Digital Plan has been expanded to provide a plan for the system, meaning timescales for development and approval routes now sit outside of the initial plan. The remaining four enabling plans have continued to develop in line with the proposed timeline, with the overarching approach and timescales shared with key stakeholders.

The enabling plans have been considered by the responsible Committees during March 25 and the plans are on the agenda today.

2.4 Operational and Financial Plan

Integrated Care Systems (ICSs) and providers are required to a submit a financial and operational plan to NHS England (NHSE) for financial year 2025/26 on 27th March 2025. Whilst this has been communicated as a final plan submission, it is anticipated that a further submission will be required on 24th April 2025.

The proposed financial plan submission for the Dorset system as at 27th March 2025 is a breakeven position, which is an improvement from the February draft plan submission. The improvement relates to alignment of system plan assumptions, changes to assumed income, and Integrated Care Board (ICB) commissioning intentions.

An extra-ordinary board meeting was held on 24 March 2025 to approve the DCH and DHC submissions and an update is included on the agenda today.

2.5 Staff Survey

I am pleased to report that the 2024 Staff Survey results have now been published. More detailed reports are included on the agenda today and I have included a brief update below. There are areas to celebrate and areas where we need to have more focus to deliver improvement.

At Dorset County Hospital, a response rate of 46.4% was achieved (1,747 employees). This is an improvement of 5.4% from last year. Out of the seven People Promise elements, five have improved and two have declined (although none of the differences in scores are statistically significant). I am pleased to report that five of the People Promise elements are significantly better than the sector average. Just one People Promise element (We are safe and healthy) scored lower than average (by 0.04%) with declining scores relating to work pressures. This continues to be a key area of focus. I am pleased to report that DCH ranks third in the South West acute trusts for staff 'agreeing' or 'strongly agreeing' they would recommend it as a place to work, with a score of 68% (with the highest scoring trust at 69%).

At Dorset Healthcare, our overall response rate has decreased to 47% from 50% in 2023 and has decreased year on year since 2020 where it was at 60.46%. We will continue to work on improving the participation levels. Mapped against the seven elements of the NHS People Promise we have improved in two of the seven people promise elements 'we are safe and healthy', 'we work flexibly' and in the 'morale' theme. We are above average in six of the seven People promise element's and both themes of staff engagement and morale. We also continue to be above average (when compared to our benchmark group) for the staff engagement score at 7.19 (compared to a benchmark group average of 7.07).

I am pleased to report that DCH ranks third in the South West acute trusts for staff 'agreeing' or 'strongly agreeing' they would recommend it as a place to work, with a score of 68% (with the highest scoring trust at 69%) and for the same metric nationally for mental health, learning disability and MH combined providers DHC ranked 12th with a score of 705.

We continue to utilise the results to identify positive outcomes, areas to improve and any trends worthy of note.

2.6 Board Changes

Prof Alastair Hutchison retired at the end of March 2025 and we welcome Rachel Wharton formally into the role of Chief Medical officer at Dorset County Hospital.

Following a competitive recruitment process we can congratulate Rachel Small on being successful in the role as Chief Operating Officer at Dorset Healthcare

2.7 Music to aid mental health

Staff from Dorset Healthcare are setting up music groups across Dorset to help patients with their mental health recovery.

Some patients with severe mental health problems have a strong emotional relationship to music so DHC occupational therapists have designed, developed, and now facilitate music groups in partnership with Absolute Music Trust (AMT).

The groups create a safe, inclusive, and therapeutic environment where individuals can connect through music, helping reduce feelings of isolation and encouraging emotional expression and boosts overall wellbeing.

Feedback from patients in the Complex Care Service shows that the initiative has positively impacted their mood and provided a sense of routine and purpose.

The project has been funded via AMT who have successfully secured bids including a generous donation through a National Lottery grant.

2.8 New solar panel funding awarded to Dorset HealthCare

Dorset HealthCare has been successful in its bid for funding for solar panels which will save the Trust around £200,000 a year.

The Department for Energy Security and Net Zero has announced a package of £100 million from Great British Energy for the NHS to install solar power and battery storage solutions to help drive down energy bills, offering better value for the taxpayer.

As part of this new funding Dorset HealthCare has been awarded £928,000 to install solar panels at six Trust sites, starting in late summer this year.

As part of work to meet NHS carbon net zero targets, DHC is switching to eco-friendly, energy-efficient equipment and making great strides in reducing its carbon 'footprint' and supporting the battle against climate change.

The Trust already buys clean, renewable energy and has previously installed solar panels at five of its locations. By using a mix of solar, wind and hydro energy, this will offset around 3,000 tonnes of CO2.

2.9 Funding to support green spaces on hospital site

Dorset County Hospital is one of only 9 hospitals selected to benefit from a national scheme that helps hospitals create thriving green spaces to support community wellbeing and local biodiversity.

The Centre for Sustainable Healthcare (CSH) has chosen DCH to be part of the national Healthy by Nature project. Funded by the National Lottery Community fund, a Nature Recovery Ranger will be based at DCH to help improve spaces and deliver activities with local community groups for hospital patients and visitors who might otherwise have limited access to nature.

The programme of activities starts in June 2025 which will bring benefits to colleagues and patients alike.

2.10 Emergency Department entrance move

The way the public access Dorset County Hospital's Emergency Department (ED) changed at the beginning of March. This has enabled main construction of the Trust's **new Emergency Department and Critical Care Unit,** part of the Government's New Hospital Programme, to start on the former Damers School site.

To help keep emergency services running smoothly during the build, people arriving at the current ED on foot or by car now access the department via South Wing, Entrance 1, with a dedicated area where Emergency Department staff will continue to ensure patients receive the most appropriate care.

Ambulances will arrive at the existing ED via a new blue light vehicle-only access road on Damers Road that goes around the construction site. The change has been carefully planned and with South Western Ambulance Trust.

Dorset County Hospital
NHS Foundation Trust

Quality Committee Assurance Report
for the meeting held on Tuesday 25 February 2025

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Concerns regarding the decommissioning of services • Receipt of an update from ophthalmology regarding the process to address lost to follow up • Positive service update from the Acute Hospital at Home service

Key issues / matters discussed at the meeting	The Committee received, discussed and noted the following reports:
	• Chief Nursing and Chief Medical Officer Update, noting
	  ○ Operational planning guidance and the difficult financial position for trusts and the decommissioning of some services by the ICB
	• Quality report including:
	  ○ The trust was on the trajectory level for C. Diff cases, with a discussion around the reasons for increased C. Diff rates nationally
	  ○ Continued focus on understanding and reducing pressure damage
	• Update to the Trust Response to NHS England Letter, noting the ongoing audit of seven-day services standard and the changes in wards in recent months.
	• Maternity and Neonatal Quality and Safety Report, noting
	  ○ Further assurance required around the risk relating to ventilators for neonates.
	• Ophthalmology update, noting the work ongoing to address patients lost to follow up
	• Service Assurance Report from the Acute Hospital at Home service, noting the positive work of the service to reduce length of stay, increase bed flow and provide positive outcomes and experience for patients and staff.
	• Quality Governance Group assurance report
	• Assurance reports from below sub-groups of the Quality Governance Group were also received for assurance.
	  ○ Clinical Effectiveness Committee

	○ Infection Prevention and Control Committee ○ End of Life Committee ○ Patient Experience and Public Engagement Committee ○ Research Steering Group
Decisions made at the meeting	• Nil
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance

	23 Apr 2024	21 May 2024	18 Jun 2024	23 Jul 2024	17 Sep 2024	04 Nov 2024	26 Nov 2024	17 Dec 2024	28 Jan 2025	25 Feb 2025	25 Mar 2025
Quorate?	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	
Claire Lehman	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	
Dawn Dawson	A	Y	Y	A	Y	Y	Y	Y	Y	Y	
Alastair Hutchison	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	
Eiri Jones	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	
Stuart Parsons	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	
Anita Thomas	Y	Y	Y	Y	A	Y	Y	A	Y	A	
Stephen Tilton	Y	Y	Y	Y	Y	A	A	Y	*No longer a member*		
Rachel Wharton	*Not a member*								Y	Y	

Baker Abi
02/04/2025 16:28:00

Dorset County Hospital
NHS Foundation Trust

Quality Committee Assurance Report
for the meeting held on Tuesday 25 March 2025

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Ophthalmology continues to be an ongoing issue, but the committee are assured that the plan to resolve the issues are in progress • Approval of Quality Committee in Common terms of reference • Approval Strategy Enabling Plans – Clinical and Quality Plan

Key issues / matters discussed at the meeting	The Committee received, discussed and noted the following reports:
	• Chief Nursing and Chief Medical Officer Update, noting
	  ○ An update on the work to resolve issues in ophthalmology
	  ○ Updates on changes at a national level
	  ○ Update on senior clinical leadership within the trust, following the retirement of the Chief Medical Officer
	• Quality report including:
	  ○ The work of the nursing and quality division to thematically cross reference and triangulate feedback data received through a variety of sources. The ways in which NEDs can triangulate information themselves to be assured that there were no recurring themes was also discussed.
	  ○ Work ongoing to align policy reporting and timely updates of policies across both DCH and DHC
	Maternity and Neonatal Quality and Safety Report, Saving Babies' Lives Q3 report, and ATAIN – Quarter 3 noting :
	  ○ Update to the risk relating to the number and age of ventilators in the service. The intention was to replace the ventilators one at a time with either capital or charitable funding.
	  ○ Plans to increase the neonatal workforce by one whole-time equivalent, which would alleviate some challenges around out of hours staffing
	• Patient Safety Incident Response Plan (PSIRP) 2025/26 noting the positive progress being made in this regard and the positive feedback of patients and families involved in the process.
	• Quality Governance Group assurance report

	• Assurance reports from below sub-groups of the Quality Governance Group were also received for assurance.
	  ○ Medicines Committee
	  ○ Mental Health Steering Group
	  ○ Patient Safety Committee
	  ○ Safeguarding Committee

Decisions made at the meeting	• Approval of Quality Committee in Common terms of reference • Approval Strategy Enabling Plans – Clinical and Quality Plan • Approval of the Learning from Deaths Q3 report
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance											
	23 Apr 2024	21 May 2024	18 Jun 2024	23 Jul 2024	17 Sep 2024	04 Nov 2024	26 Nov 2024	17 Dec 2024	28 Jan 2025	25 Feb 2025	25 Mar 2025
Quorate?	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Claire Lehman	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y
Dawn Dawson	A	Y	Y	A	Y	Y	Y	Y	Y	Y	Y
Alastair Hutchison	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	A
Eiri Jones	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y
Stuart Parsons	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y
Anita Thomas	Y	Y	Y	Y	A	Y	Y	A	Y	A	Y
Stephen Tilton	Y	Y	Y	Y	Y	A	A	Y	*No longer a member*		
Rachel Wharton	*Not a member*								Y	Y	Y

Report to	Board of Directors, Part 1	
Date of Meeting	8th April 2025	
Report Title	Maternity and Neonatal Quality and Safety Report	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, CNO	
Previously Considered By	Quality Assurance Committee 25.03.2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 – Safety and quality	
Financial	Achieving the Maternity Incentive Scheme (MIS) provides approx. £250k rebate to maternity services	
Statutory & Regulatory	Elements in this report relate directly to Maternity Incentive Scheme	
Equality, Diversity & Inclusion	Not specifically	
Co-production & Partnership	Nil	

Executive Summary

This report sets out the quality and safety activity covering the month of February 2025 (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

- Significant reduction in Datix submission relating to maternity staffing and delayed induction of labour.
- Staffing challenges continue to feature in neonatal Datix submissions
- There was an increase in term admissions to the neonatal unit. All cases are reviewed by the ATAIN team to identify any themes or avoidable admissions
- There were three incidents of low harm. Currently being reviewed by the Governance Team
- One third degree tear relating to a spontaneous birth
- The Risk Register has been updated
    - 1980 EPAC (Early Pregnancy Advice Clinic) changed to three-month review as service provision maintained by reallocating a midwife and using bank staff
    - 2031 Cover for Reception has improved significantly with very few shifts vacant. Review will now be quarterly. Risk value is still moderate as the impact of there being no reception cover hasn't changed and there are still a few vacant shifts each month
    - 1881 The business case to increase funding for neonatal nursing has been approved, to improve nursing staffing overnight. However, the risk remains high (15) due to vacant shifts continuing to be covered daily by bank, overtime hours, and constant shift swaps from permanent members of staff, agency and by reallocating staff from quality roles.
    - 1898 In discussion with the neonatal matron currently confirmed three working ventilators. The risk is about spare parts and repairs. Risk reduced by DoMN Services to 'unlikely' to reflect rare event of needing three ventilators or needing two ventilators and two being faulty.

- Two complaints received
  - Failure to provide basic care on readmission, including refreshments. Lack of a robust readmission policy for women and babies
  - Breach of confidentiality relating to next of kin information
  - Poor communication when reviewing a pregnant woman anxious about her baby's movements
- Workforce data – 12.3% shifts not fully staffed by midwives in February. However, sickness in February <3% for midwives
- Training figures overall very good. Compliance amongst 'other' anaesthetic doctors is red as compliance is 40% currently.
- SBL summary slide shows excellent progress and compliance (more details in separate paper)

Recommendation

Board are requested to:

- **Discuss and receive the report for assurance**

Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

March 2025

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

Executive Summary

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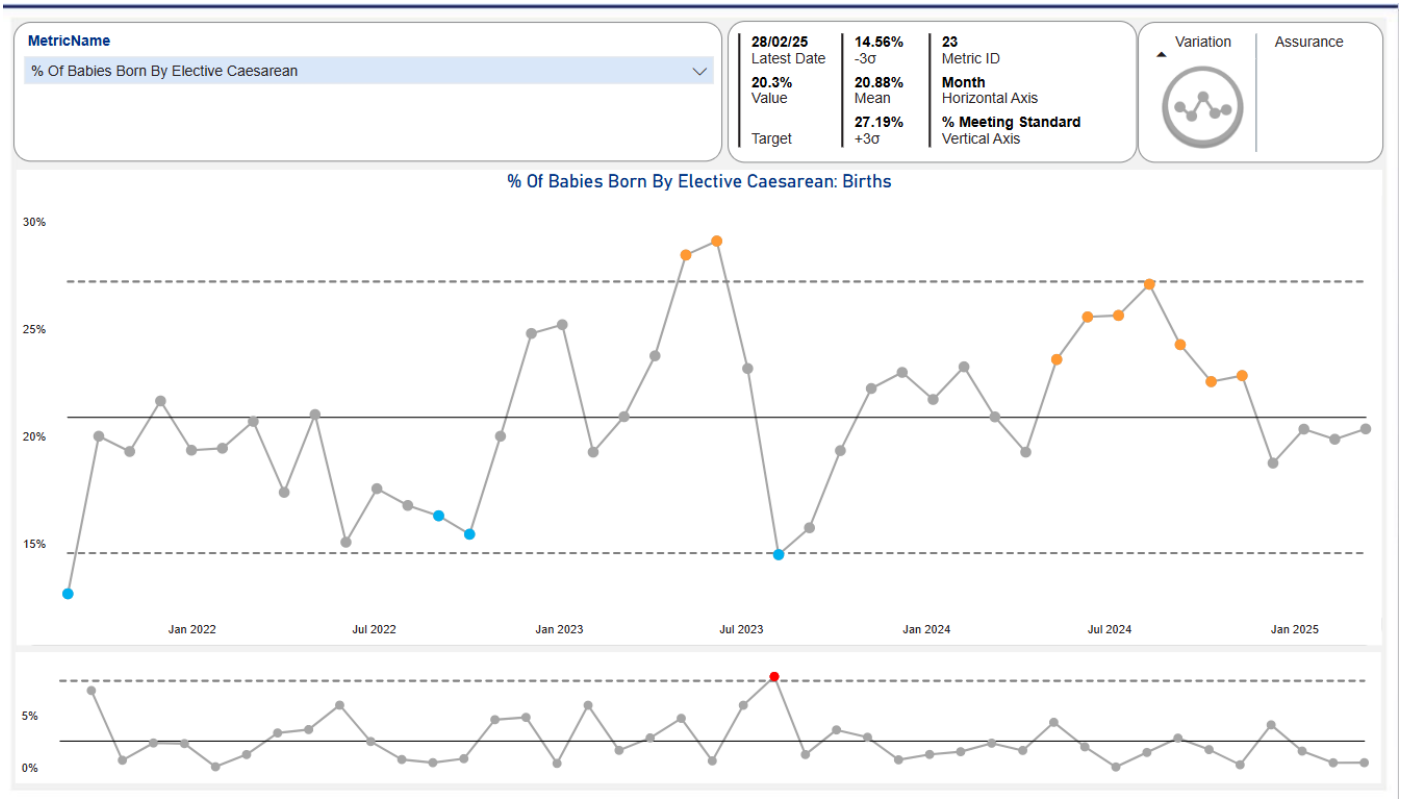
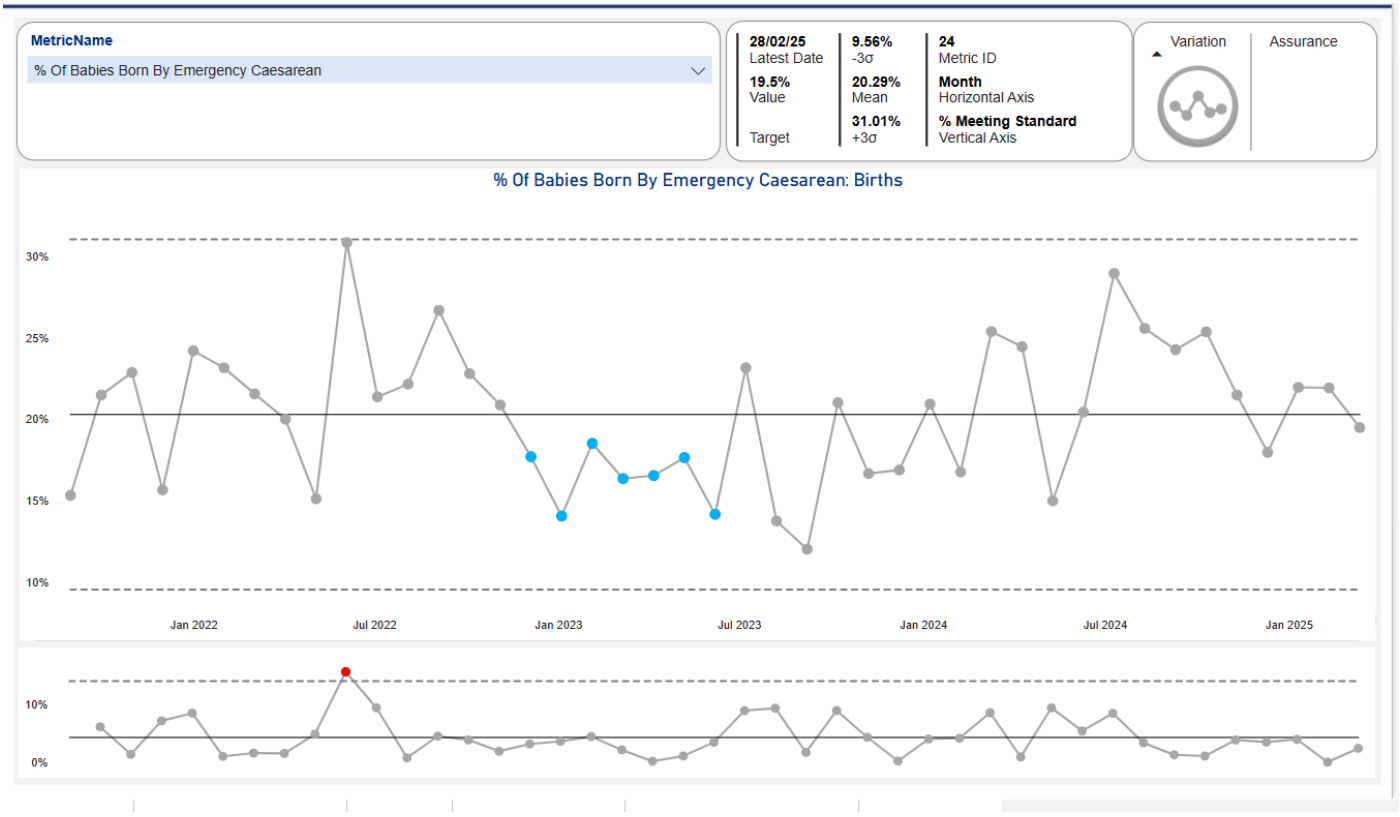
- Training figures overall very good. Compliance amongst 'other' anaesthetic doctors is red as compliance is 40% currently.
- SBL summary slide shows excellent progress and compliance (more details in separate paper)

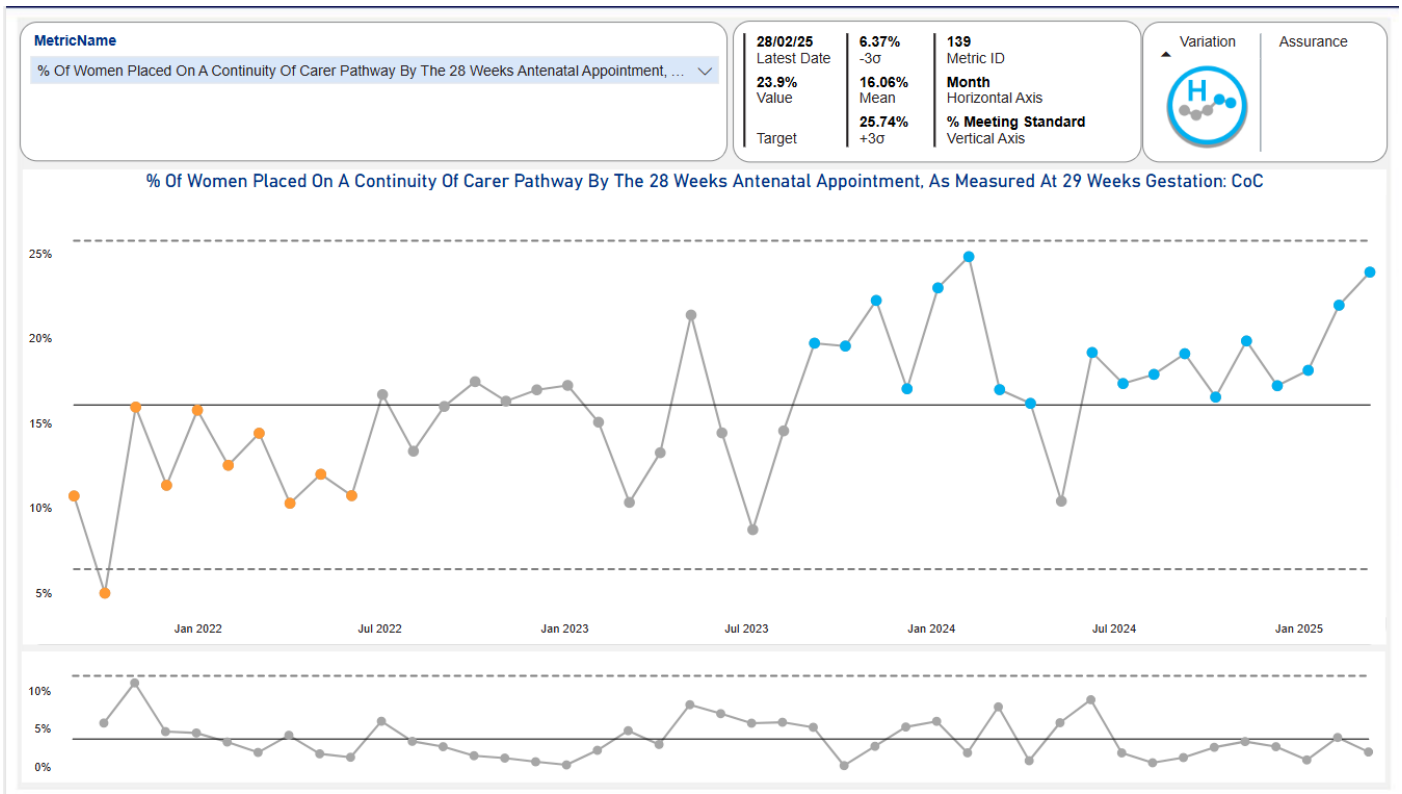
Exception report for SPC charts (NTI – no target identified)

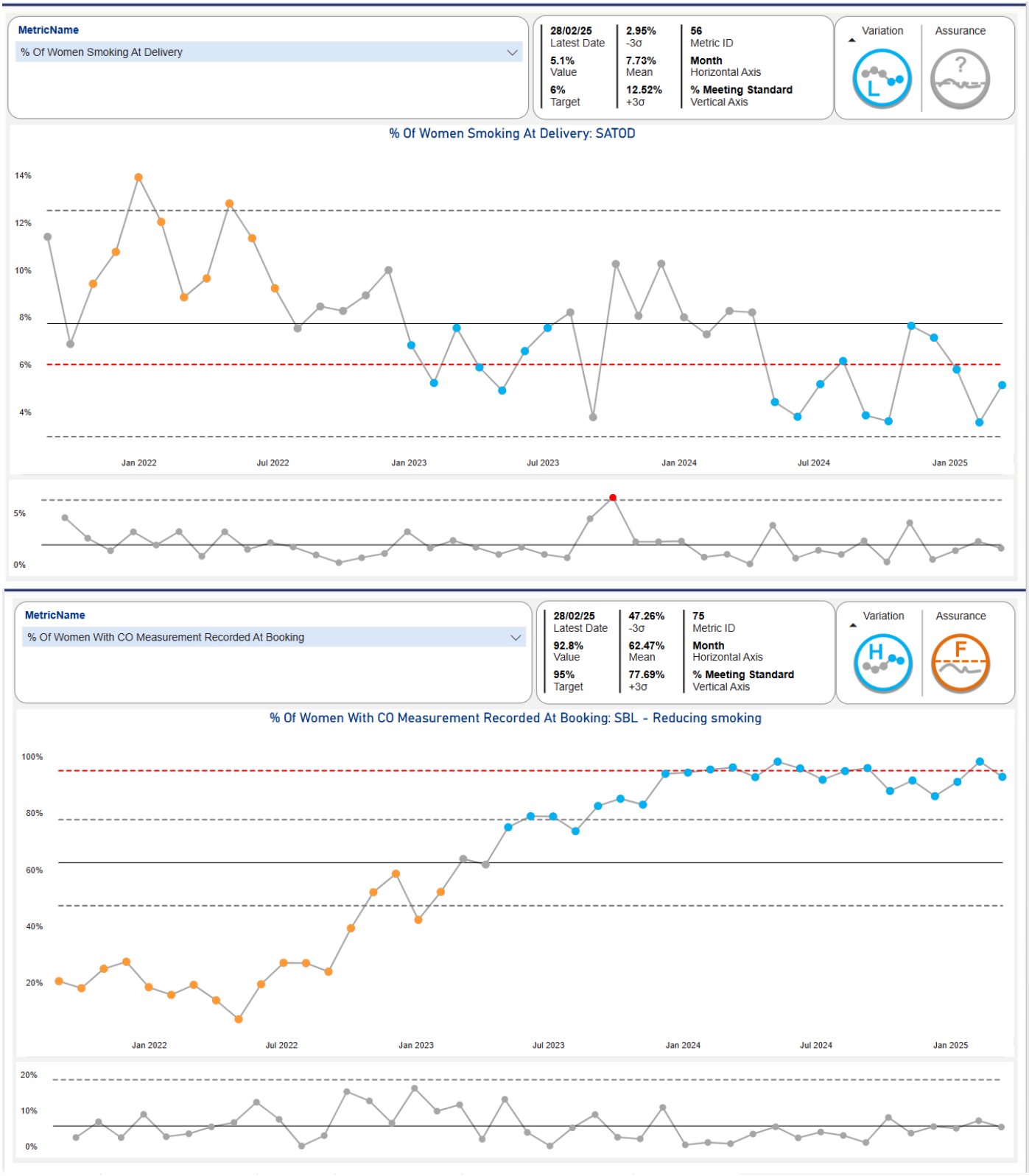
Metric	Target	Current position and mitigation/actions
% babies born by elective caesarean	NTI	20.3%
% babies born by emergency caesarean	NTI	19.5%
% women on a continuity of care pathway by 28 weeks	NTI	23.9%
% women smoking at time of delivery	6%	5.%
% CO recorded at booking	95%	92.8%
% CO record at 36 weeks	95%	96.9%
Number of stillbirths		nil
Number of neonatal deaths		nil
% babies >37 weeks admitted to SCBU	5%	9.9%
Rates per 1000 of PPH >1500mls (current 3 months)	30	38.7

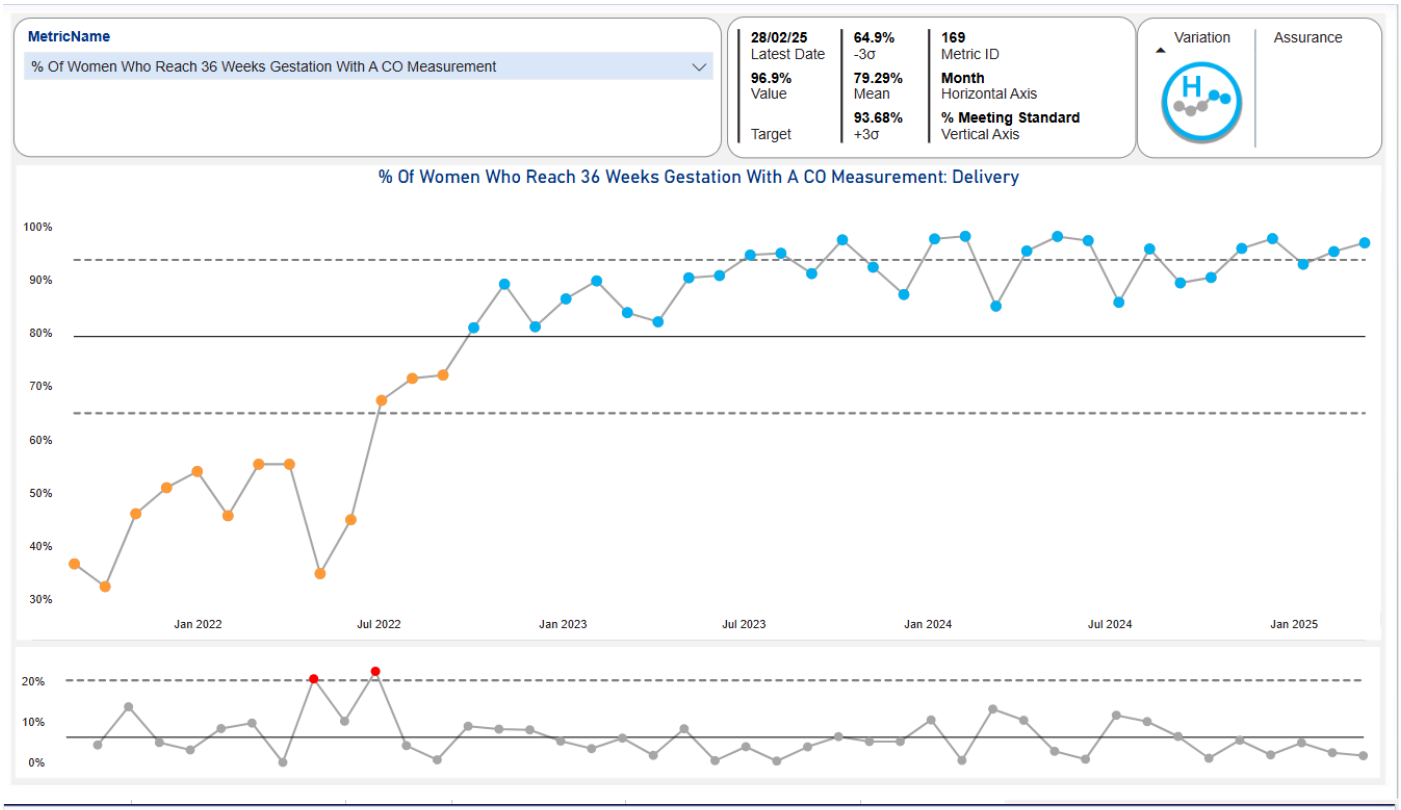
Rates per 1000 of 3rd/4th degree tears (current 3 months)	25	19
% live births <37 weeks gestation	6%	7%
Hypoxic Ischemic Encephalopathy incidents		Nil
Percentage of babies with 1st feed maternal	NTI	79.5%

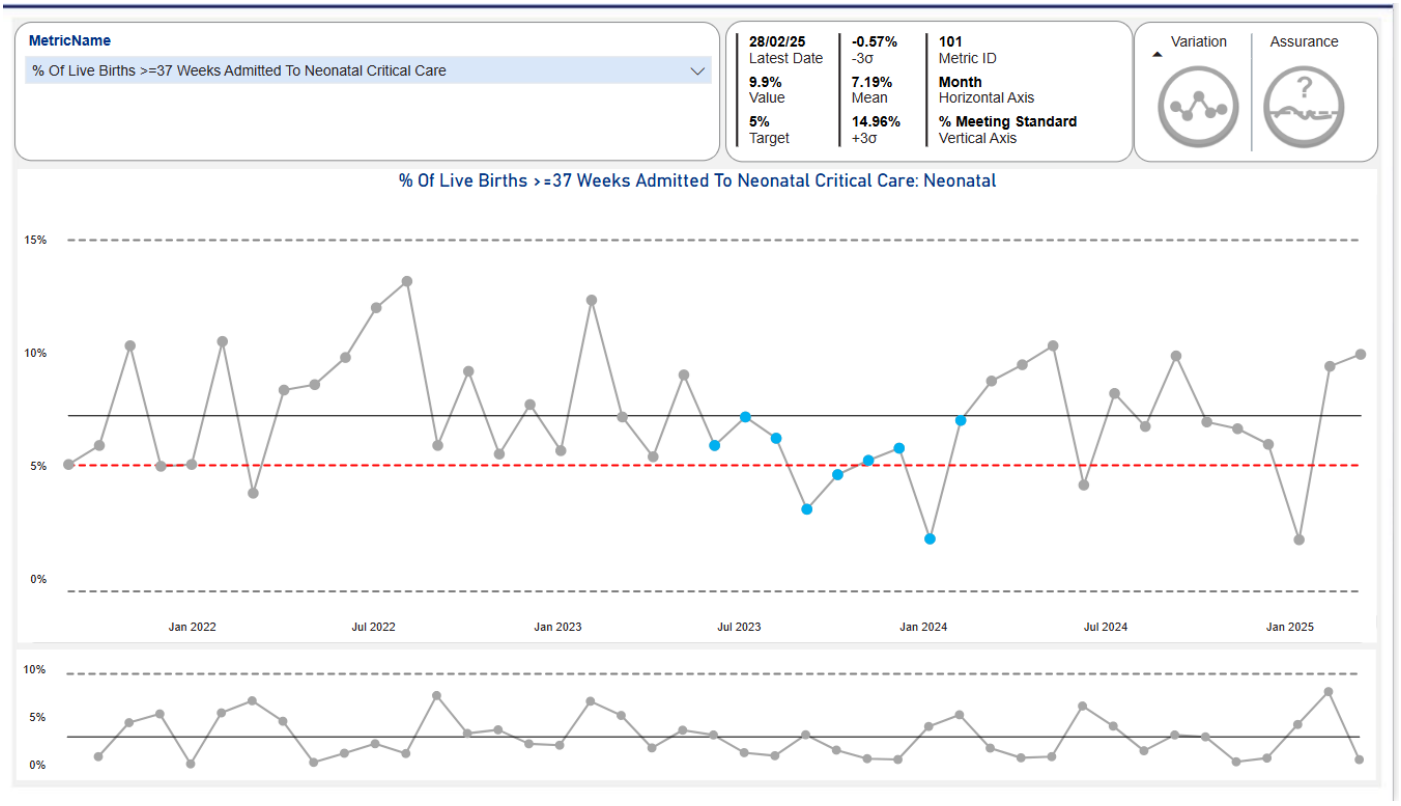


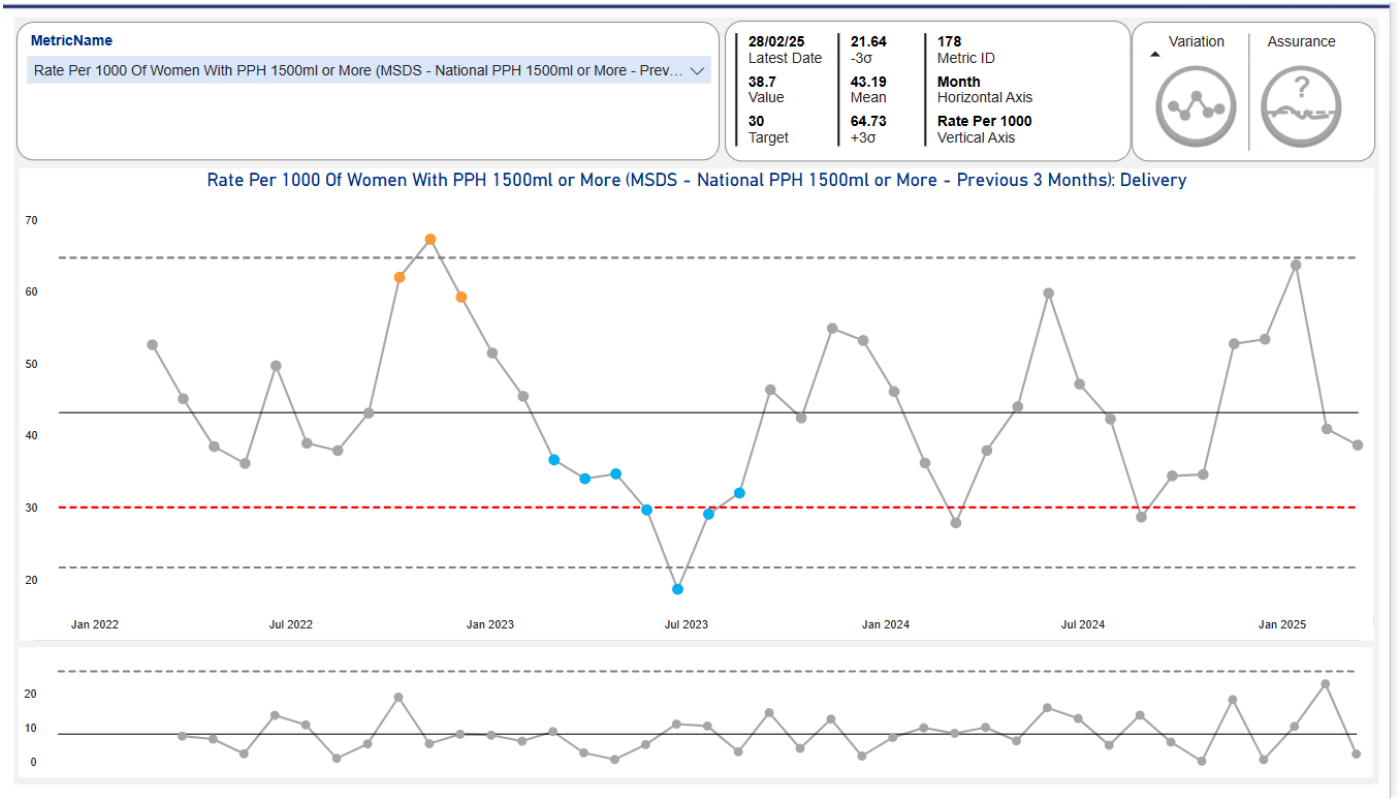


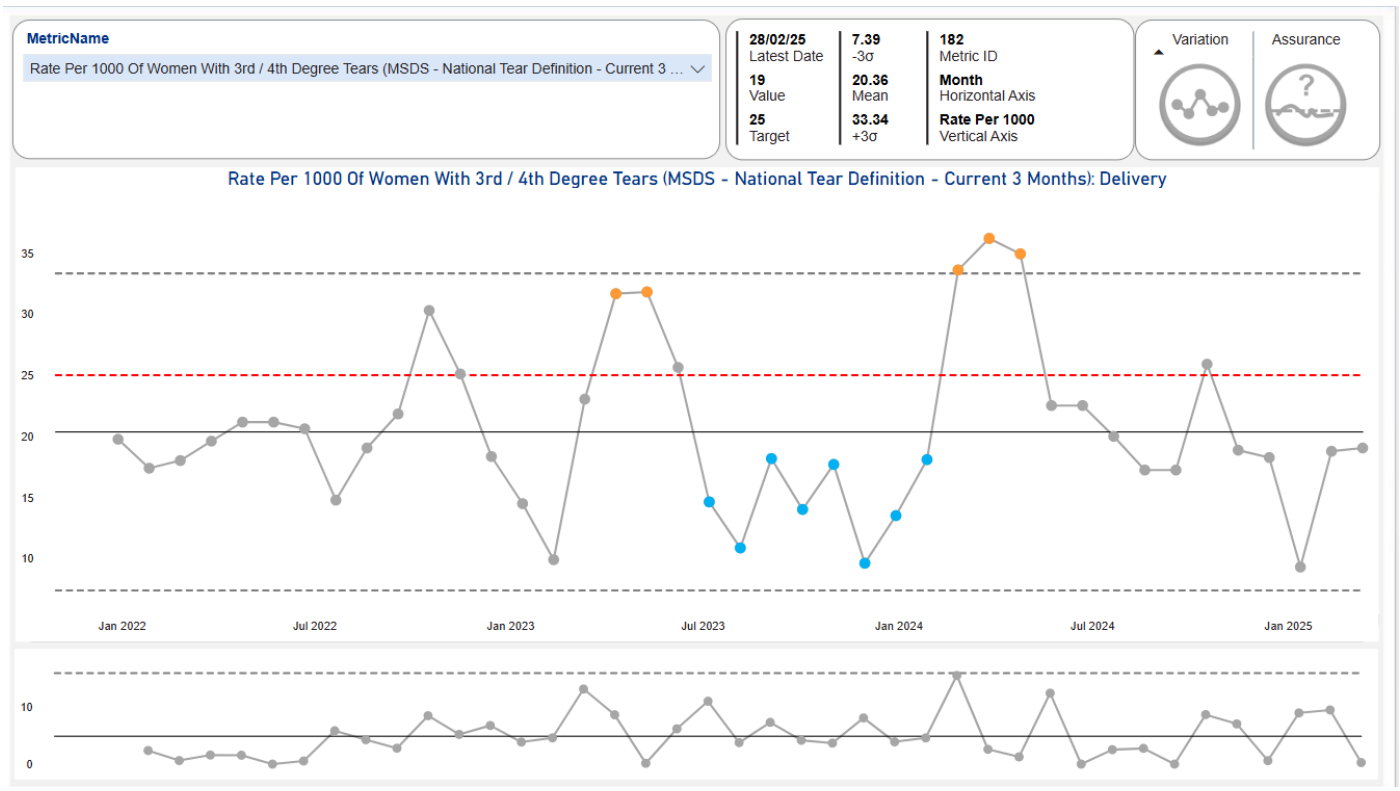


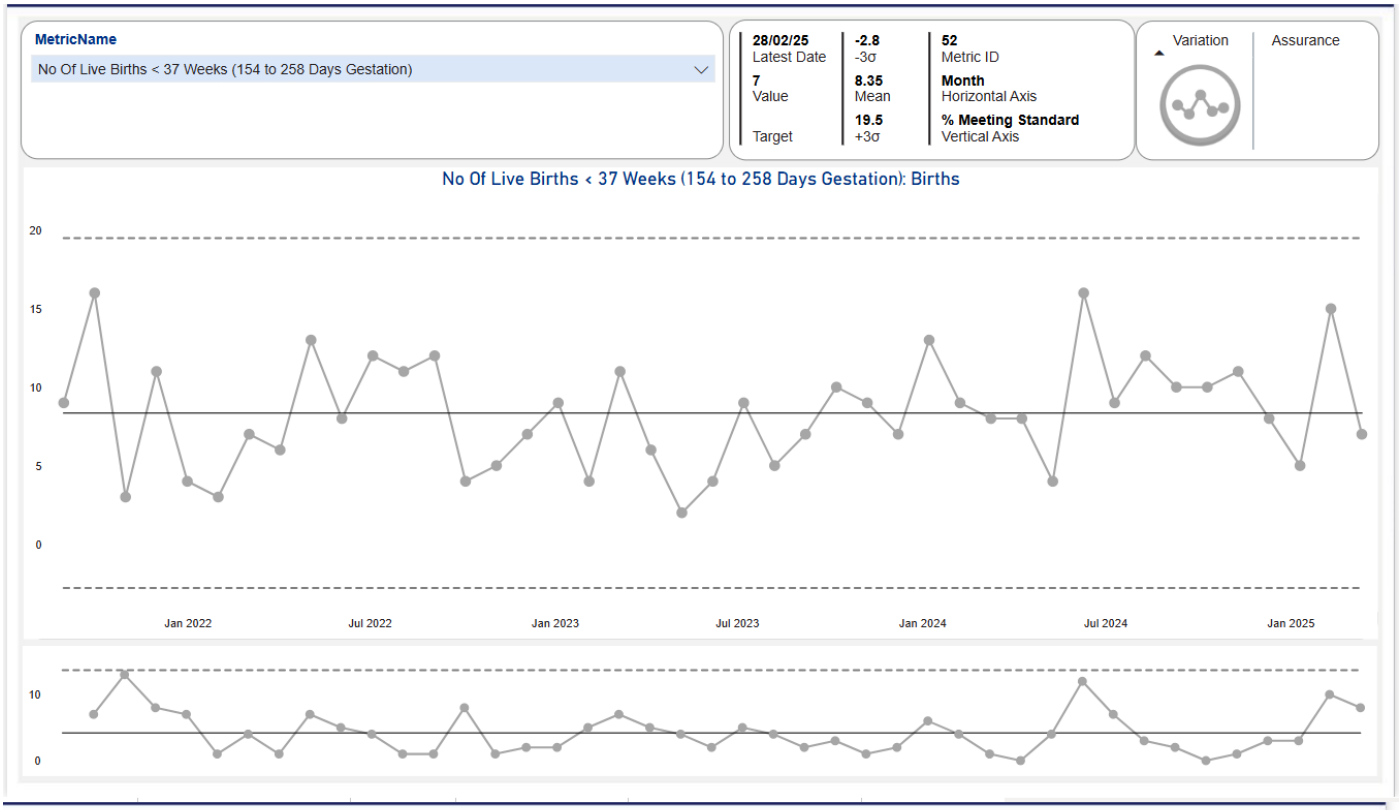


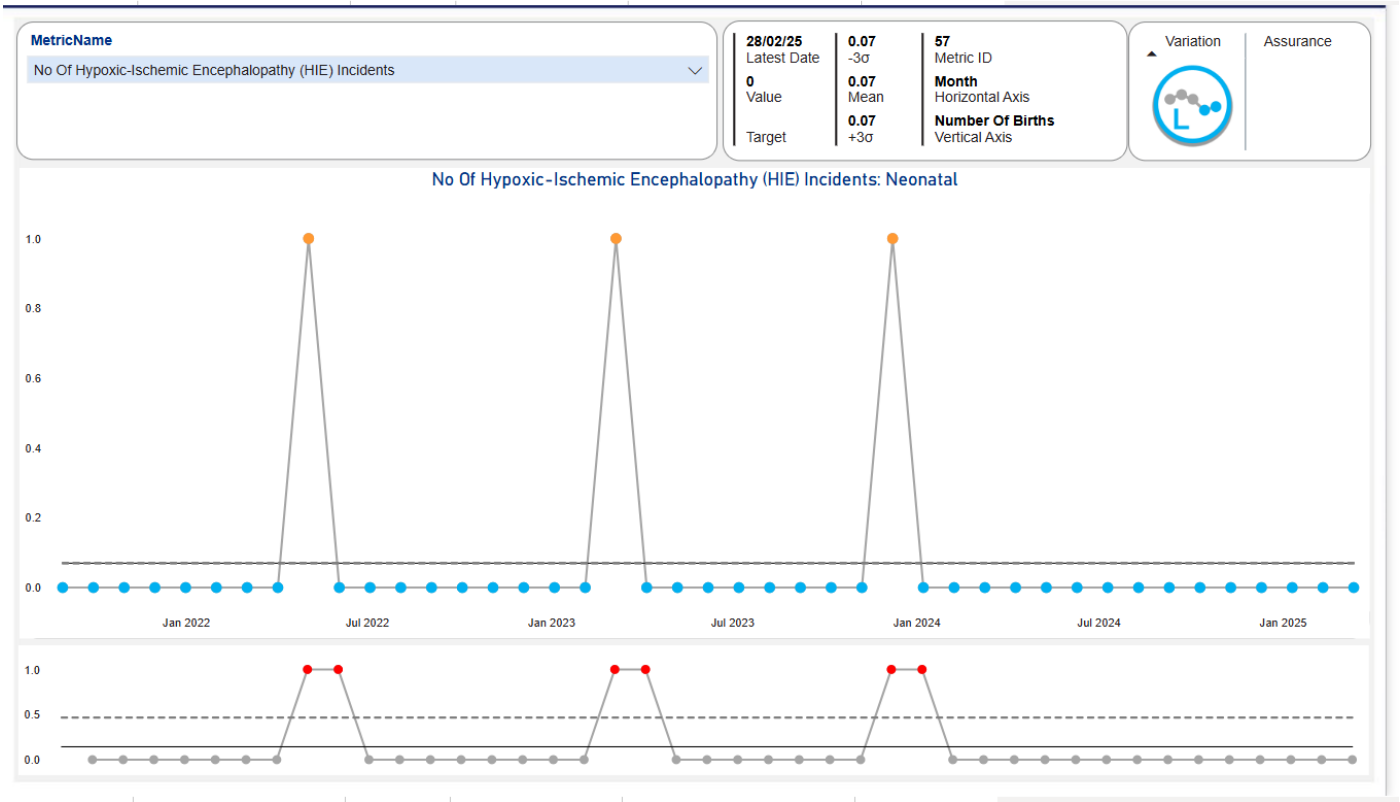


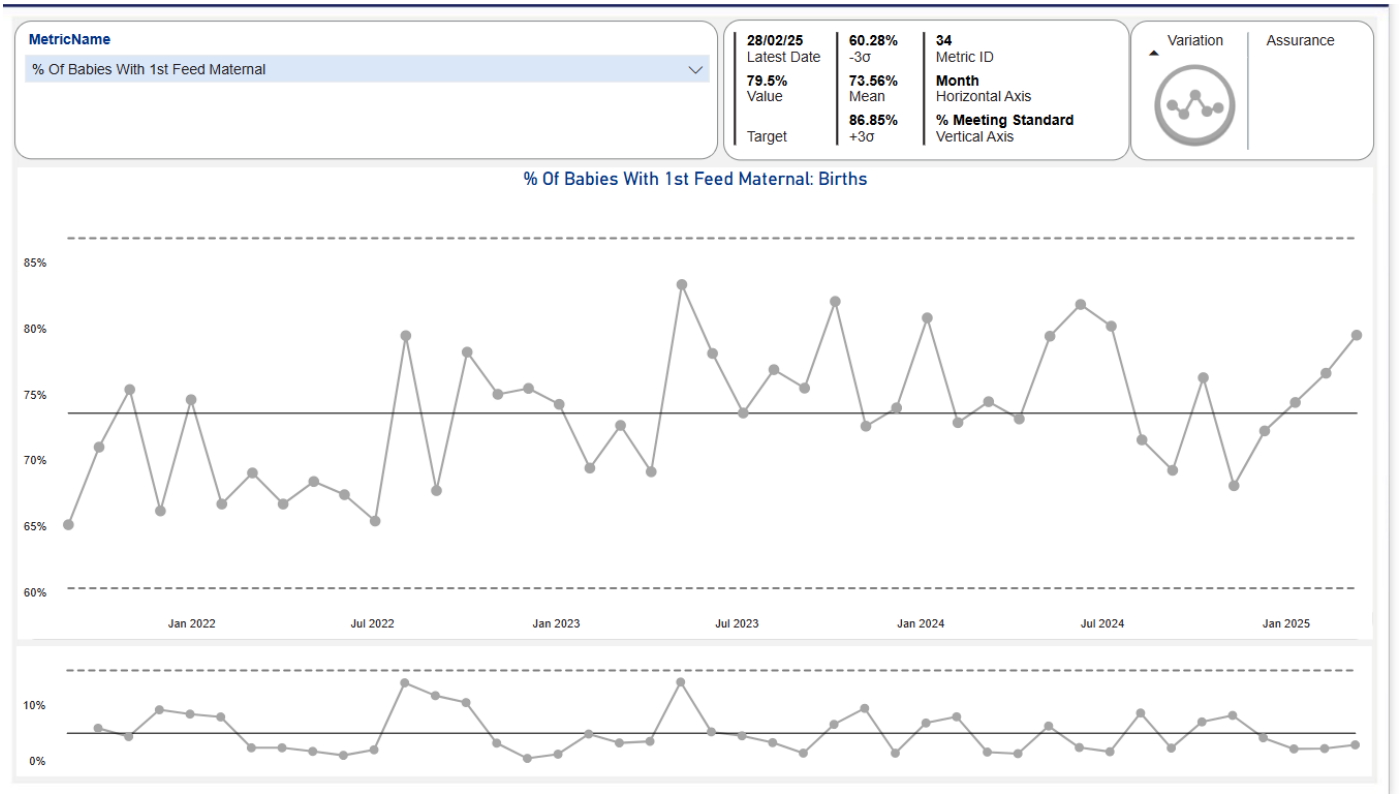












Total Number of Incidents submitted for February 2025

maternity & neonatal
78

Red Flag incidents: A midwifery red flag event is a warning sign that something may be wrong with staffing.

Red flag	Descriptor	Incidents for January
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	1 for maternity, 4 for SCBU
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	1
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	2 Datix for delayed IOL
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	0
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	

Harm	Incident	Action
Low harm	Shoulder dystocia	Will be reviewed through the ATAIN process
Low harm	MOH (massivie obstetrc haemorrhage)	This will be reviewed by the MDT that reviews all MOHs >1500mls
Low harm	Delay in genetics appointment	Review by the screening team of referral processes to the regional centre. Support provided to the family.

3rd & 4th degree tears February

Ethnicity	Parity	BMI	Grade of tear	Mode of birth	Hands on	OASI	Position of woman	Baby's weight	Blood loss	Referral made
			3C	spontaneous	yes	yes	Semi prone		550mls	yes

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
1980	EPAC restricted service	Originally this risk related to the national requirement to have a 7-day EPAC service. However, a resignation has resulted in a rota gap as of the end of January. Currently unable to recruit into the vacancy as the additional post was a cost pressure added > 1 year ago. The consequence is EPAC will only open 3-4 days a week from February 2025. Increasing demand on ED when the service isn't available and providing a poorer patient experience for women anxious about their pregnancy **Update** Currently EPAC remains open for most Mondays - Fridays. However, this comes at a cost pressure to maternity as a midwife has been reallocated to EPAC and vacant shifts are being covered by bank staff. I am changing to three monthly reviews as the service is being maintained across nearly all days (last month, 2 weekdays it was closed). Business case has been submitted	20/09/2024, Jo Hartley, DoMN Services, quarterly review	9	Division

2031	Maternity Reception Cover	Currently, maternity reception is not always staffed. This is a risk to security and impacts on the Day Assessment staff who are repeatedly asked to open the door. This takes them away from clinical care and puts their patients at risk. This was identified at the Insight Visit as a significant risk and one that required immediate attention. Currently in consultation with staff to change working patterns to provide more cover. Maternity Support Workers are being allocated, where possible to cover Reception when required. **Update** Cover for Reception has improved significantly with very few shifts vacant. Review will now be quarterly. Risk value is still moderate as the impact of there being no reception cover hasn't changed and there are still a few vacant shifts each month	19/12/2024, Jo Hartley, DoMN Services, monthly review	Moderate 9	Division.
2020	Completion of Neonatal Screening on day 5 as Required by National Screening Team	National Screening Team expect all babies to receive their NBBS (newborn blood spot screening) on the 5th day of life. DCH does not have community services on a weekend and has a drop-in on a Sunday only. Therefore, babies due their NBBS on Saturday, receive it on Sunday, day 6. No clinical consequences identified **Update** In January, we are trialing a weekend drop-in postnatal clinic on both Saturday and Sunday. If sustainable, this will mitigate the problem of not completing the test on day 5 (other than for those families who refuse to attend). Update due April 2025	03/12/2024 Janet Johns, Screening Coordinator, quarterly review	Moderate 8	Care group
1959	IT systems allowing manual input of pathology results by clinical teams	It has been recently brought to the attention of Serious Hazards of Transfusion (SHOT) that the UK maternity patient data management system as supplied by Badgernet allows clinical staff to manually input patient pathology and other test results into the system. This may impact decisions related to patient care including blood group, red cell antibody screen and identification results. Other clinical systems that use pathology data may be similarly impacted. A preliminary national review of cases submitted to SHOT in the last 3 years revealed at least 12 incidents where the cause of the preventable error was a manual transcription error in the maternity IT system. **Update** There has been no progress with a digital solution (none expected in this time frame). No further incident noted. Update due in May 2025	06/09/2024 Chloe Mackenzie, Digital Lead Midwife, quarterly review	Moderate 8	Care group

1881	Neonatal Nursing	Current neonatal nursing establishment not compliant with safe levels of staffing according with BAPM and Neonatal Nursing workforce Calculator. Regular bank and overtime hours required each month to cover the unit with 2 RN and 1 HCA. Agency is used too, when no other option is available. Establishment not sufficient to cover 3 members of staff on duty at all times. And no additional nursing wte for supernumerary shift lead coordinator (as per National Service specification). **Update** Neonatal Nursing staff are expected to deliver care inside the different rooms in the unit, on labour ward, post-natal ward and in some emergency situations attending A&E and Main Theatres. To maintain safety of staff, infants and carers we require a minimum of 18.21WTE (3 x 6.07), as per the Neonatal Nursing workforce Calculator. Our establishment only accommodates a total of 15.18wte. **Update** Staffing on the neonatal unit continues to be very challenging, often on a day-to-day basis. Agency is still used regularly with tier one and tier two incentives being offered. Specialist roles are constantly being reallocated to clinical work, impacting on mandatory KPIs. However, there has been agreement to fund the SCBU business case, investing in an extra band 6 nurse for the service. We are awaiting confirmation to begin the recruitment process	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, monthly review	High 16	corporate
1827	Electronic health record unavailable for SCBU	Paper documentation used for infants admitted to SCBU. Electronic health record (Badgernet) plus minimal use of paper records used for infants under Transitional Care. This has resulted in two different systems being used for infants admitted to SCBU/TC by the same team. Additionally, SCBU staff are reliant upon desktop PC's rather than the iPad. **Update** Update due June 2025	26/02/2024 Debora Pascoal-Horta Neonatal Matron, quarterly review	Moderate 9	Care group

1825	Ventilator SLE 5000	Current ventilators available in SCBU (X3) reached end of life and the period of maintained support has now passed. The current models in the unit ceased manufacturing in May 2015 and the 7year period of maintenance support has now passed. Currently the devices only have a standard service contract. This means that a repair is not guaranteed due to non-availability of spare parts. Standard contract until 28/02/2025. Risk highlighted in the 2024/25 Capital Programme for prioritisation as needing replacement as soon as possible **Update** Risk escalated at QC 25/2/25. Action taken at that meeting for an understanding of the prioritisation of this replacement against other equipment due as per the capital replacement programme. J Howarth to report back to NEDs at QC. EJ (NED) clear that this risk should not be tolerated as despite the incidence of requiring more than 1 ventilator at a time very low, the event could be catastrophic if all ventilators were not in working order at the same time. Currently no guarantees that if a ventilator fails, it can be repaired. Proposal for 1 ventilator to be replaced first as part of a phased approach and to mitigate risk. In discussion with the neonatal matron currently confirmed three working ventilators. The risk is about spare parts and repairs. Risk reduced by DoMN services to 'unlikely' to reflect rare event of needing three ventilators or needing two ventilators and two being faulty	26/02/2024, Debora Pascoal-Horta, neonatal matron, quarterly review	Moderate 6	care group
1898	Resuscitaires for labour ward	The CQC inspection and report highlighted the need to have a resuscitaire for every labour room. This requires the purchase of two new resuscitaires. Scoping exercise underway to identify a suitable model. Possibility of procurement with neighbouring trust. Initially sat with the Capital Replacement Programme but likely need to seek charitable funding. There have been no cases of a resuscitaire not being available for every labouring woman **Update** Three new machines received. Risk closed	28/05/2024, managed by Jo Hartley DoM, monthly review	closed	division

1689	Opening a second theatre in an emergency &the elective pathway	All incidents where a second theatre is required are reviewed by the Safety Team and where relevant through M&M or other specialist groups. A second issue is the lack of a senior midwife to accompany the team to a second theatre out of hours (only one band 7 midwife overnight). This inevitably results in a midwife with considerably less experience coordinating a high-risk situation (as the coordinator cannot leave labour ward). Discussions starting about establishing a pathway for elective theatre work - planned caesareans. This would require 4 split theatre sessions a week, a theatre team including surgical first assistant, anaesthetic and obstetric consultant availability **Update** Risk assessment required in relation to the SOP for management of a second theatre in an emergency. To review choice of theatre location, equipment provision, allocation of a resuscitaire, transport of neonate, care of partner **Update** This workstream continues, led by the Intrapartum matron. Update due April 2025	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
1742 & 1759	Additional obstetric consultant capacity required to meet national KPIs	Currently providing obstetric and gynae services on a 1:7 rota with 8 consultants. Unable to provide nationally mandated level of care to some high-risk groups of women. Also unable to provide a consultant evening (8pm) face to face handover. New consultant has made a very successful start with the service. F2F handover and ward round acknowledged as a priority but will require job plan review as changes in on call provision from some consultants impacts these arrangements. Likely funding for tenth consultant – awaiting confirmation **Update** The new consultant starts in April. This addition will ensure the f2f evening ward round can be instigated	013/10/2023, managed by James Male, Service Manager, quarterly review	Moderate - 12	Division
876	Maternity Staffing	Heath roster being reviewed in line with funding streams to ensure all posts are represented in the business case. BR Plus audit if safe staffing commenced. Vacant shifts continue relating to LTS, STS, maternity leave. Staff reallocated from community and specialist roles to ensure safety on labour ward but evidence of staff burnout and stress levels increasing. **Update** BR Plus report received and business case to be written. The BR Plus report advises 7wte extra midwives required in order to provide safe clinical care. This includes the 1.8wte to contribute to UHD for the Maternity Advice Line. Currently >4% midwifery shifts not fully	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly reviews	Moderate 12	corporate

		staffed. Risk level reduced. Update due May 2025			

Complaints for maternity and SCBU

Total informal and formal

Month	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
total	2	6	3	2	1	1	1	1	1	3	2	2

Themes
Failure to provide basic care on readmission, including refreshments. Lack of a robust readmission policy for women and babies.
Breach of confidentiality relating to next of kin information
Poor communication when reviewing a pregnant woman anxious about her baby's movements

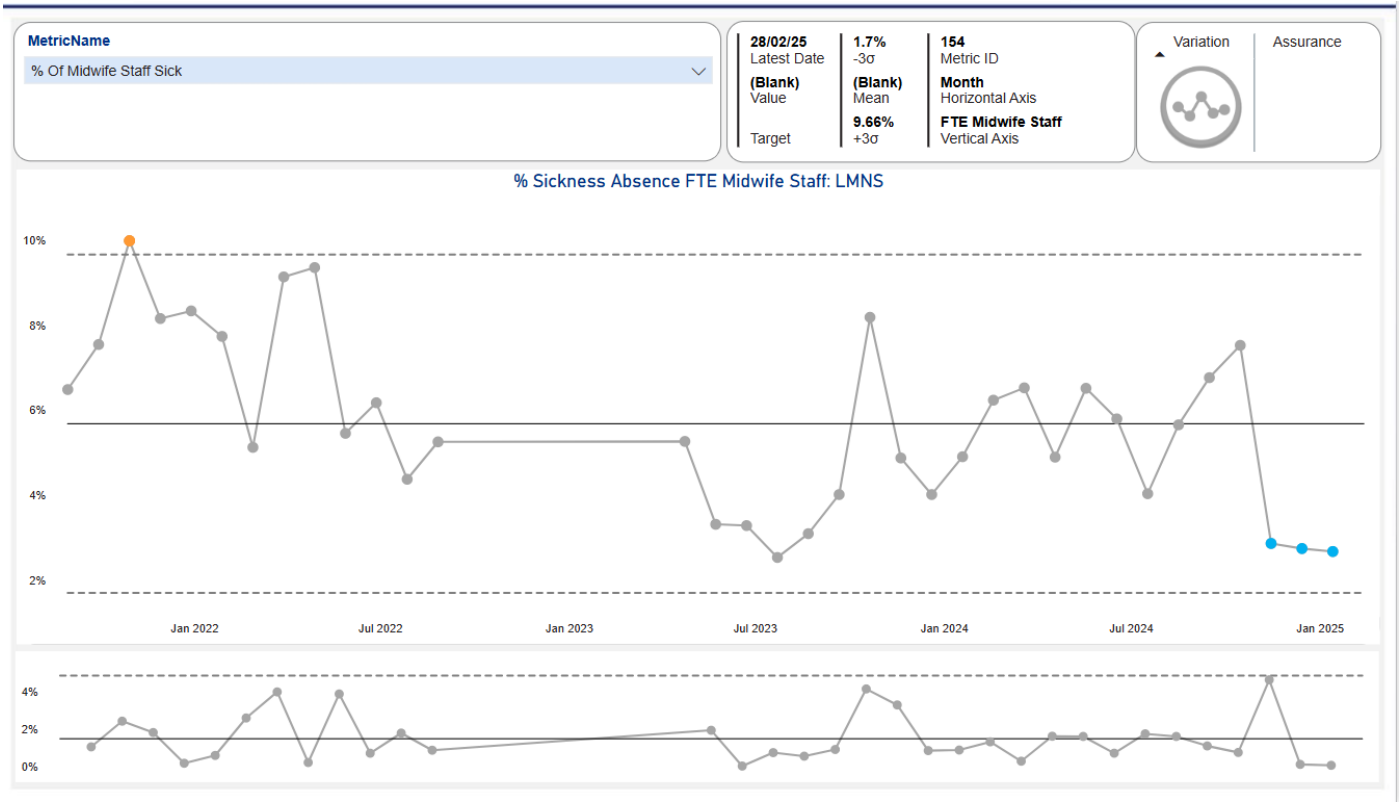
Neonatal transfer out data for February

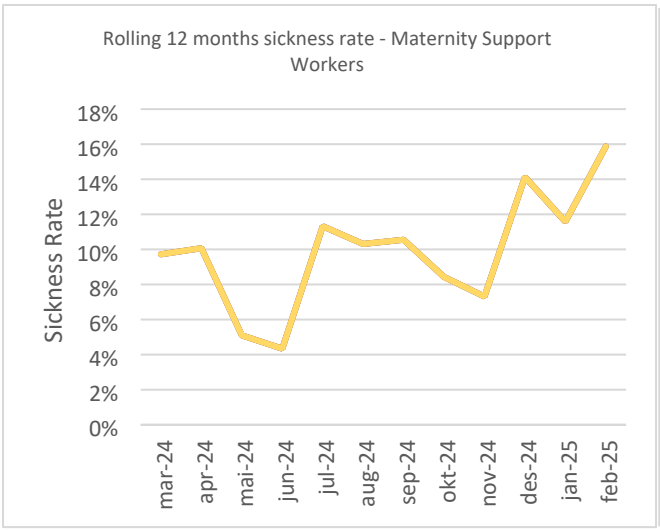
34/40		PAH, Southampton. (further transferred from NICU to E1-paediatric cardiology ward at Southampton General on day 11 for further investigations into continued SVT)
41/40		Transferred to Southampton NICU for cardiac review. Nothing abnormal identified and repatriated 8 hours later

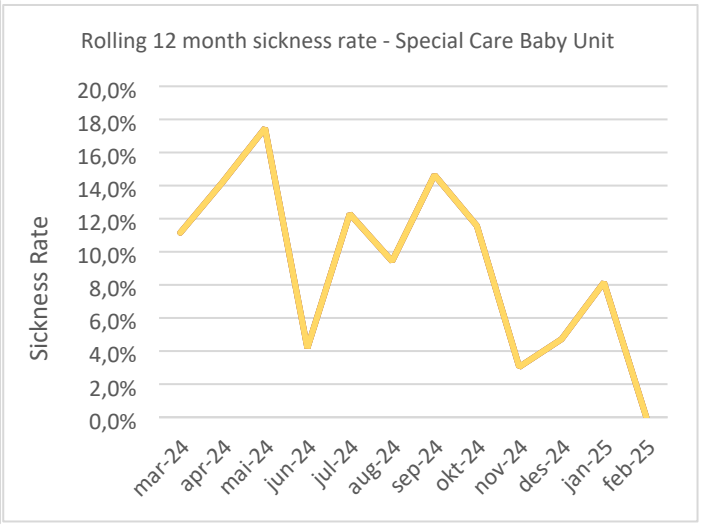
Neonatal exceptions (babies that should have been transferred out of SCBU)

36/40		Intubated and ventilated for 27 hours and 36 minutes. Frequent discussions with SONET and baby extubated onto High Flow therapy successfully on SCBU.

Workforce data







<u>Overall sickness rates from 1st February 2024 – 31st January 2025</u>
Midwives – 6.61%
Maternity Support Workers – 9.35%
Special Care Bay Unit – 10.04%

February Call-Out Hours

Midwife call-out for the unit – **74.4 hours.**
Senior Midwives call-out – **72.4 hours**

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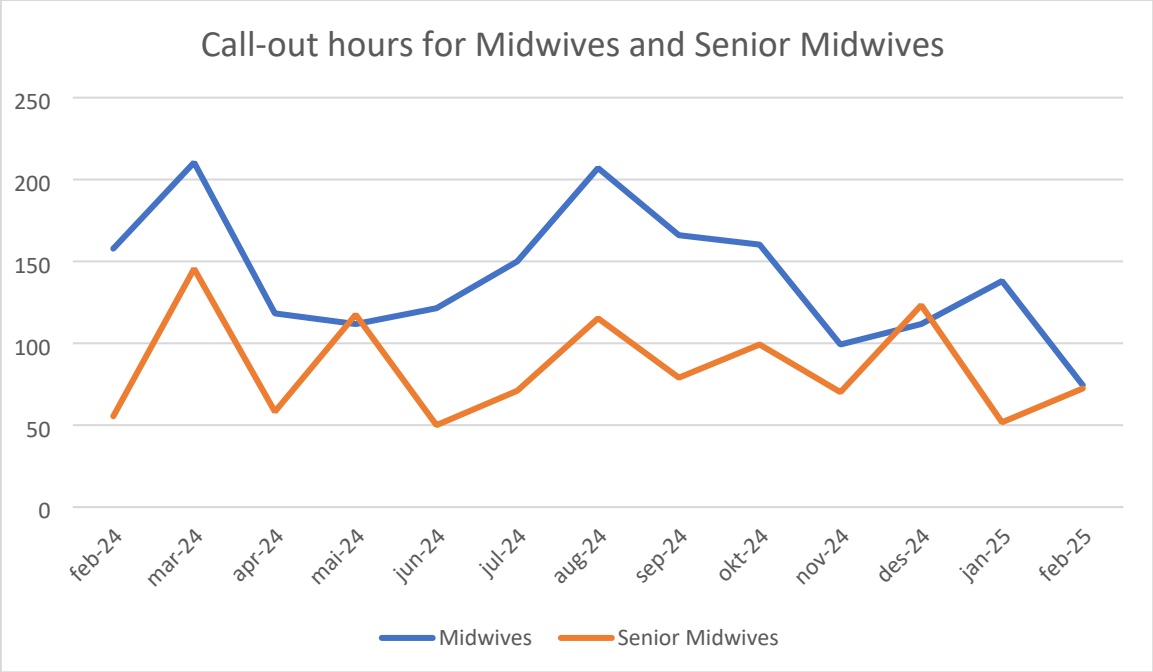
02/04/2025 16:28:00



Bank and Excess hours

	Maternity Unit/ DAU	MSW's / DAU	SCBU Band 5/6	SCBU Band 3
Bank	201.75 hrs / 76.5 hrs	24.5 hrs / 43 hrs	256.25 hrs	46.5 hrs
Excess/Overtime	494.5 hrs	93.5 hrs	262.52 hrs	

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		**Special Care Baby Unit**	
Day Shift	13.09%	Band 5/6	1 shift not covered
Night Shift	10.71%	Band 2	5 shift not covered
Total	**12.3%**		
Maternity Support Workers			
Day Shift	20.5%		
Night Shift	12.5%		
Total	**17.85%**		

Babyloss for February

Baby loss statistics for February			
Intrauterine death	Medical termination	Neonatal death	Late neonatal death
0	0	0	0

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02/04/2025 16:28:00

Training Figures for February

Key	
≥90% compliance	
<90% compliance	

Training	Role	Compliance (percentage)	Non-compliance (number)	Narrative
Practical Obstetric Emergency Procedure Training (PROMPT)	8.10: 90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	92%	1	BAU
	8.11: 90% of all other obstetric anaesthetic doctors commencing prior to 1 July 2025	40%	3/5	3 new staff added to this group, not yet attended, previous anaesthetic staff in this group have changed cohorts for MIS - as per the Obstetric Anaesthetic leads (who manage the anaesthetic cohorts and compliance for MIS). Date changed to 1st July 2025. MIS year 6 technical guidance below, pending further update. 90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors **who contribute to the obstetric anaesthetic on-call rota**. This updated requirement is supported by the RCoA and OAA.
	8.12 Rotational Anaesthetic staff starting on/after 1st July 2025	100%	0	BAU
	70% of non-obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity.	93%	2	BAU
	Consultant Obstetrician	100%	0	BAU
	Registrars	80%	2	Expected compliance in April due to rostering.

	SHOs ST1/F2/GP Trainees	89%	1	Expected compliance in March due to rostering.
	Midwives	98%	2	BAU
	MSW	95%	2	BAU
Neonatal Basic Life support (NBLS) Yearly	Midwives	93%	9	BAU (2 bank staff chased)
	Paediatric SHO's rotational	100%	0	
	Paediatric SHOs non-rotational	100%	0	
	MSW's Band 3 in PN Care	100%	0	
	HCAs	100%	0	
	Neonatal nurses	94%	1	
	Paediatric Consultants	73%	3	X2 study days per year for NLS and airway skills (BAPM requirements). First date for 2025 is March 2025. Consultants – study day is March 19th. All consultants have been emailed by Dr Clare Hollingsworth SCBU lead and facilitator of the study day.
	Paediatric Registrars	100%	0	
	ANNP	100%	0	BAU
RCUK Neonatal Life Support (NLS) Certification 4 Yearly	Senior & Cygnet Midwives	100%	0	BAU
	Neonatal nurses	100%	0	BAU
	Paediatric Consultants	100%	0	BAU
	Paediatric Registrars	100%	0	BAU
Saving Babies Lives study day	Midwives	92%	10	BAU
	Consultants	100%	0	BAU
	Registrars	100%	0	BAU
	SHOs	78%	2	Expected compliance March.

SBLv3 Element 1	Intervention 1.8 – CO monitoring Midwives and MSWs giving AN care	92%	13	BAU
	Intervention 1.9 – VBA all staff – m/w's, obstetricians and MSWs	94%	9	BAU
	E2.11 Practical SFH Assessment	93%	10	BAU
K2 CTG & IA	Consultants	100%	0	BAU
	Registrars	100%	0	BAU
	Midwives	96%	5	BAU

SBL summary

Saving Babies' Lives (Version 3.1) Board Report

Dorset Local Maternity and Neonatal System

We're proud partners of Our Dorset – Health, care & wellbeing

NHS Dorset

Trust	Dorset County Hospital
Date of report	28/02/2025
Review period	Q3 2024/25
ICB accountable officer	Pam O'Shea (Interim ICB Chief Nursing Officer)
Trust accountable officer	Alastair Hutchison
LMNS peer assessor name(s)	Vicky Garner (LMNS Lead Midwife)

Executive summary:

- 60% of targets with a stretch ambition are either meeting or exceeding the stretch ambition
- Element 1 (Smoking in Pregnancy) has seen some regression in compliance and is an area for focus.
- Implementation plans for a continuity of carer team in line with Core20PLUS5 (element 5, intervention 5.14) is a key priority to be achieved in 2025/26.
- Perinatal mortality review tool reporting shows no associated risk of harm identified.
- Saving Babies' Lives version 3.2 expected for release by April 2025.

% of interventions fully implemented (LMNS Validated)		Q1	Q2	Q3	Q4
	Element 1 Smoking in pregnancy:	70%	90%	70%	
	Element 2 Fetal growth restriction:	95%	90%	95%	
	Element 3 Reduced fetal movements:	100%	100%	100%	
	Element 4 Fetal monitoring in labour:	40%	100%	100%	
	Element 5 Preterm birth:	85%	96%	93%	
	Element 6 Diabetes:	100%	100%	100%	
	Total implementation (all elements):	84%	94%	91%	

Agreed Improvement Activity and Shared Learning

Element 1	Areas for improvement identified in: • CO verified quits in smokers at 4 weeks (1.6, process indicator 1e) • Percentage of smokers at booking who are identified as CO verified non -smokers at 36 weeks (1.6, outcome indicator 1d) • Percentage of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not engage with tobacco dependence treatment service (1.7)
Element 2	• Ratified standard operating procedure for uterine artery doppler assessment (2.7) needed to enable element 2 to be fully implemented. • Shared learning to be presented at LMNS safety meeting in March 2025 on the MDT thematic analysis process introduced in line with PSIRF for babies with a birthweight below the third centile, born after 37 +6 weeks' gestation (2.18)
Element 3	Good improvement seen with next working day ultrasound scans for patients who attend with recurrent reduced fetal movements (3.2)
Element 4	• Achieving stretch ambition in 4 of 5 metrics within interventions 4.1 (fetal surveillance training and competency assessment), 4.2 (risk assessment at the onset of labour) and 4.3 (hourly holistic review) • Aim to achieve stretch ambition in all interventions by end of quarter 3 2025/26 to include 4.4 (peer review) which is currently exceeding the minimum ambition of 80%.
Element 5	Areas of achievement to be celebrated in: • Significant improvement in compliance with MSU at booking for patients at risk of preterm birth (5.11) • Rates of preterm babies receiving maternal breastmilk (5.25) exceeding regional and national average. • Assurance of outcomes provided in exception reporting process.
Element 6	• Hybrid closed loop interventions expected in new version (3.2) of Saving Babies' Lives.

Report to	DCH Board of Directors	
Date of Meeting	08 April 2025	
Report Title	Learning from Deaths Q3 2024/25	
Prepared By	Dr Julie Doherty / Prof Alastair Hutchison	
Approved by Accountable Executive	Dr Rachel Wharton	
Previously Considered By	Hospital Mortality Group, 05 March 2025 Quality Governance Group 12 March 2025 Quality Committee 25 March 2025	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality	
Financial	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	
Statutory & Regulatory	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement. An elevated SHMI will raise concerns with NHS E&I and the CQC. The reduction in SHMI is acknowledged, and the overall trend in DCH's SHMI is favourable.	
Equality, Diversity & Inclusion	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	
Co-production & Partnership	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	

Executive Summary

The purpose of the report is to inform the Board of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite a previously elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.

- The latest published SHMI data (5 months in arrears) for DCH was 1.043 This is within the expected range. SHMI data is showing a decreasing trend at DCHFT with the most recent result the best figure for many years.
- Despite the reassuring SHMI trend and latest figure we are not complacent. We continue to review our depth of coding in case we notice that SHMI is being adversely affected by the lack of resources within the clinical coding dept. Uncoded activity affects our expected mortality. There has been a recent decrease in depth of coding but this now appears stable and not further reducing.

- The backlog of SJRs awaiting completion in Division A is in the process of being addressed.

Recommendation

Board are requested to:

- Receive the report for **approval**

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

5.0 MORBIDITY and MORTALITY MEETINGS

6.0 LEARNING FROM CORONER'S INQUESTS

7.0 LEARNING FROM CLAIMS

8.0 SUMMARY

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a quarterly report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning.

1.1 Family Services and Surgical Division Report - Quarter 3 2024/25 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 57 deaths in quarter 3, of which 52 that require SJR's to be completed. Within quarter 3 58 SJR's have been completed from this quarter and previous months. The division reports having sufficient numbers of reviewers and that SJR backlog relates mainly to the delay in receiving deceased records (DPR is not appropriate for conducting SJRs).

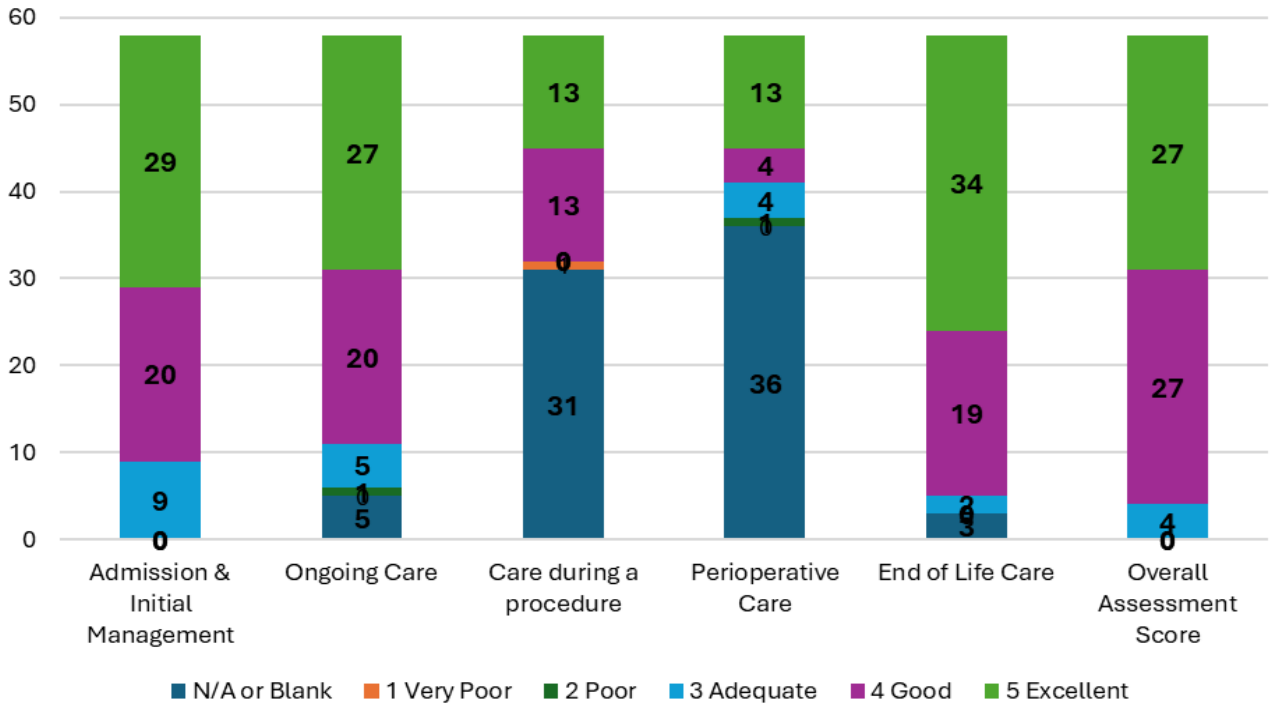
Outstanding SJR's:

The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 09/02/2025 is 12:

October	November	December
4	2	6

Feedback from SJR's Completed in Quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	5	31	36	3	0
1 Very Poor	0	0	1	0	0	0
2 Poor	0	1	0	1	0	0
3 Adequate	9	5	0	4	2	4
4 Good	20	20	13	4	19	27
5 Excellent	29	27	13	13	34	27



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	2	5	23	28

The Quality Manager continues to monitor when the Mortuary/Clinical Coding have released the records to obtain them before they go to the scanning team to try and mitigate being scanned to DPR before the SJR has been completed.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	7	51

Action Required:

Following completion of the 58 SJR's, 4 were highlighted as requiring actions.

Further learning via:

- 3 were for formal documented feedback to Department or clinical team – this is completed at the time of the SJR completion.

Other actions:

- 1 was for review and discussion at Specialty M&M/Clinical Governance meetings – completed.

SJRs are now routinely being completed by both Medical and Nursing staff to provide an MDT approach and ensure all aspects of a case are reviewed.

Learning from Division:

1. Delay in PICC line due to no vascular access service. No TPN for 5 days. Affecting patient care. Business case to be reviewed and escalated to Clinical Effectiveness Committee.
2. Continued poor surgical clerking with omissions in PMH, Meds and cardiovascular / respiratory examination. Divisional director with clinical lead(s) meeting to discuss efforts for quality improvement.
3. Need to fill out TEP if DNAR. Presentation of TEP Policy to clinical leads group and consider further communication methods to relevant medical staff.
4. High Quality ED documentation

1.2 Division of Urgent & Integrated Care – Quarter 3 Report 2024 / 25

In quarter 4 there were 177 deaths, 51 SJR's were requested from these deaths, and 5 SJR's were completed during this period (completed SJR's not necessarily from this quarter). The division is in the process of review and establishing a new system for SJR review.

	Q3			Q4			Q1			Q2			Q3		
	Oct	Nov	Oct	Jan-24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Deaths	49	41	49	41	49	41	48	52	45	75	105	82	59	65	53
Deaths requiring SJR'S from Month	11	14	11	14	11	14	9	8	15	6	22	26	14	12	15
*Completed SJR'S	20	12	20	12	20	12	6	10	9	1	9	2	4	0	1

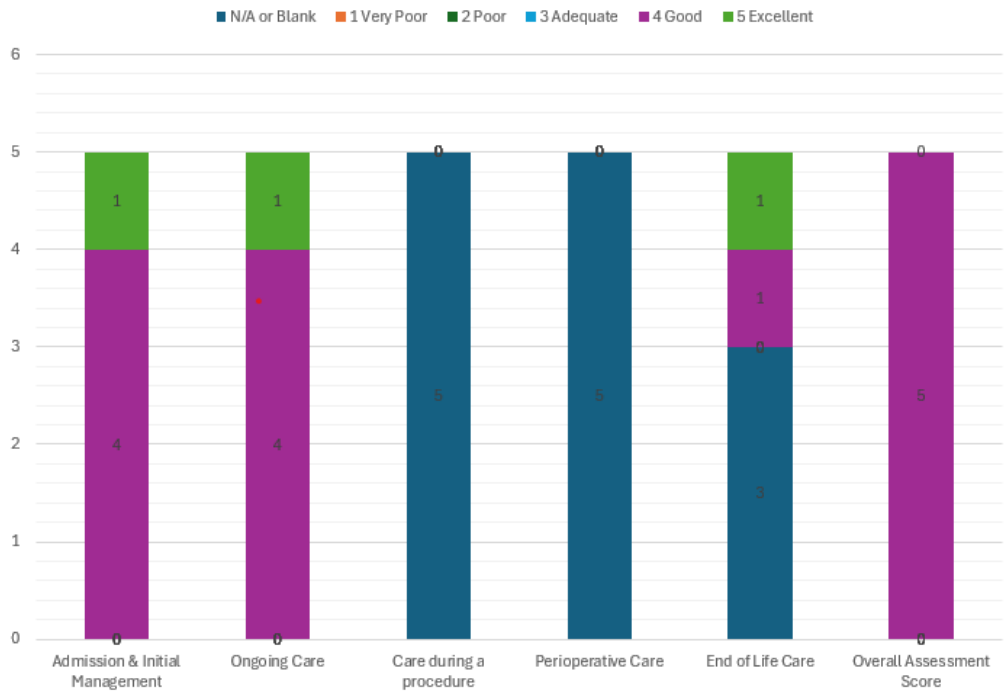
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division for Q3

October	November	December
10	12	14

Phase score from 20 completed SJR's in quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	0	5	5	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	0	0	0	0	0	0
4 Good	4	4	0	0	1	5
5 Excellent	1	1	0	0	1	0



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	0	5	0

- Good record except ED agyle notes
- Clear handwriting, dated and signed entries bar one.
- Very detailed, all notes appear to be present.
- Good documentation on Agyle. Clear plan from medical team.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	0	5

Action Required:

Following completion of the 5 SJR's, 0 required further action as they were all scored as 'definitely not avoidable'.

SJR Key themes from Areas of Good Practice:

- Good involvement of patient and/or family, good documentation, Prompt Consultant review

- Good involvement of patient and/or family, Thorough assessment, Good documentation, Prompt Consultant review, Second opinions sought where appropriate

SJR Key theme of Areas for Improvement:

- Improve ED documentation
- Could have been started on IV Antibiotics for possible cold sepsis on admission but delay of 1 day - did not have an impact on outcome.
- Slow response from endocrinology team to a referral regarding thyroid function though this did not impact on outcomes.
- Earlier Tep B review.
- Delayed transfer to ward due to bed capacity, so was in ED for nearly 17 hours.

For further LfD and QIP see section 4.

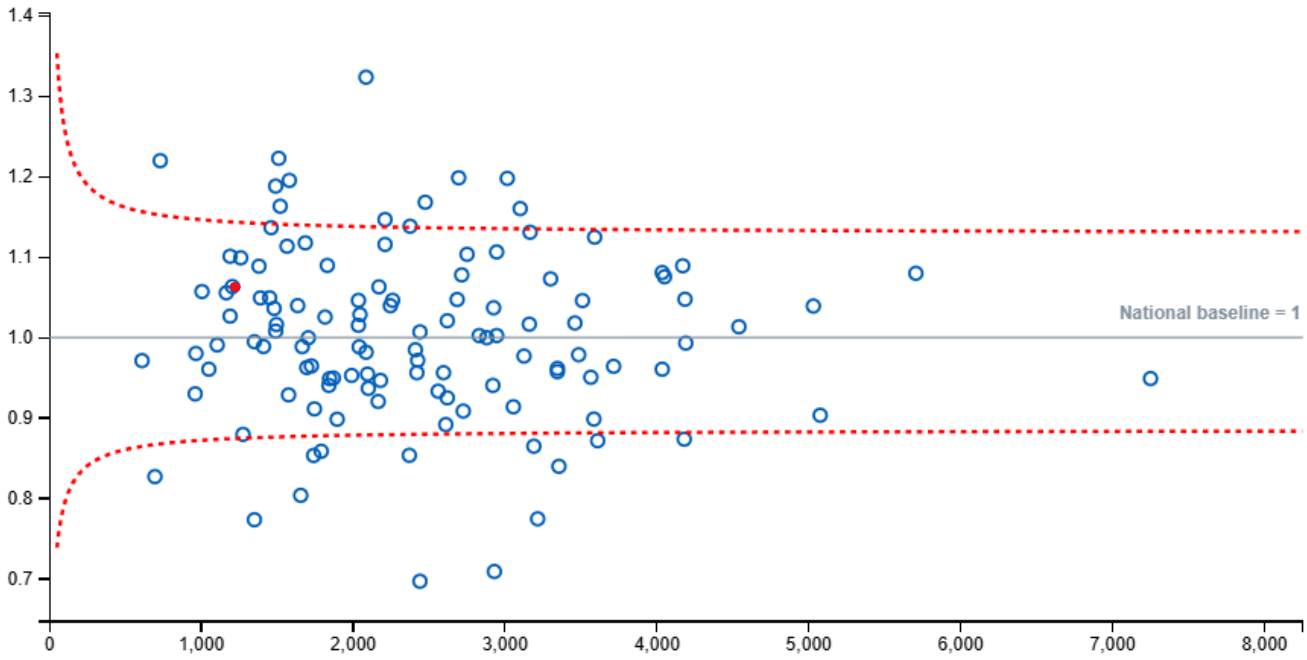
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

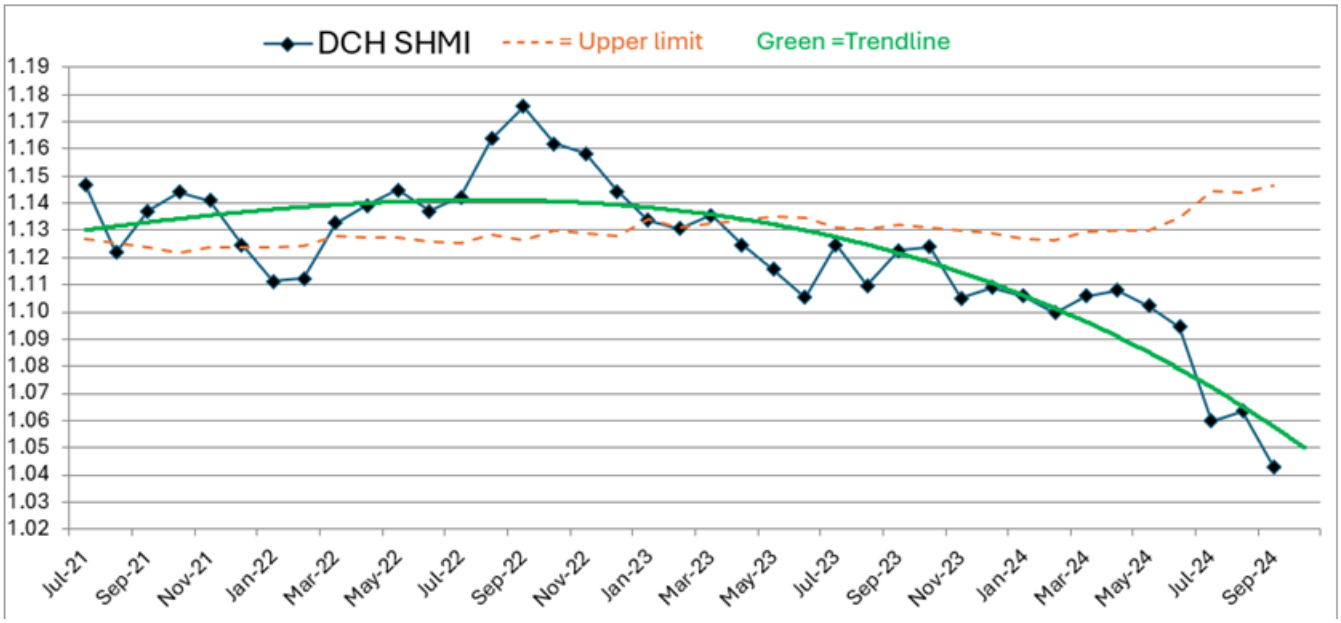
2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

The latest SHMI publication for funnel plots from NHS England is for the period Sep 23- Aug 24. **The Trust's figure at that stage was 1.0634. which is within the expected range** using NHS England's control limits. The preview SHMI data for the upcoming publication is even better at 1.043.

DCH =red dot

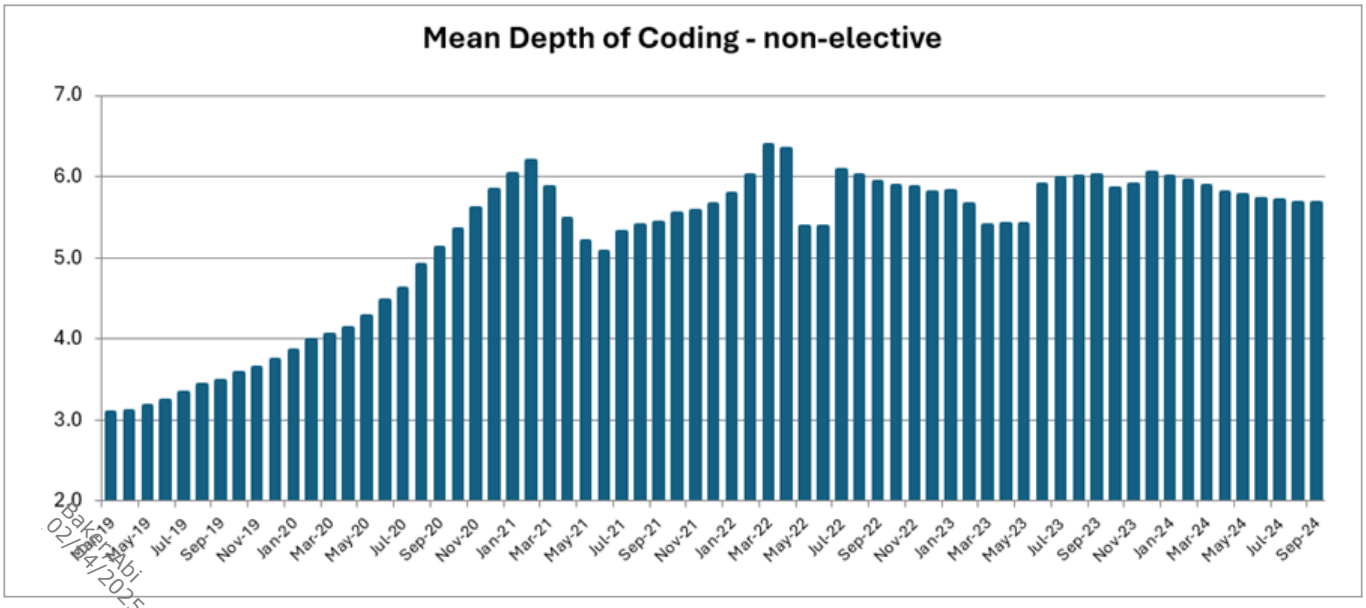




2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities but may also be due to differences in coding practices between trusts*."

DCH's depth of coding had previously stabilised at around 6.0 – in line with the national average for non-elective admissions. Whilst our depth of coding remains reduced at 5.7, this is relatively static and is not to date impacting SHMI which continues to fall. Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which helps significantly but there remain concerns regarding lack of resources available to coding. DCHFT mean depth of coding for elective admissions remains further below the England Average at 5.3(compared to 6.2).

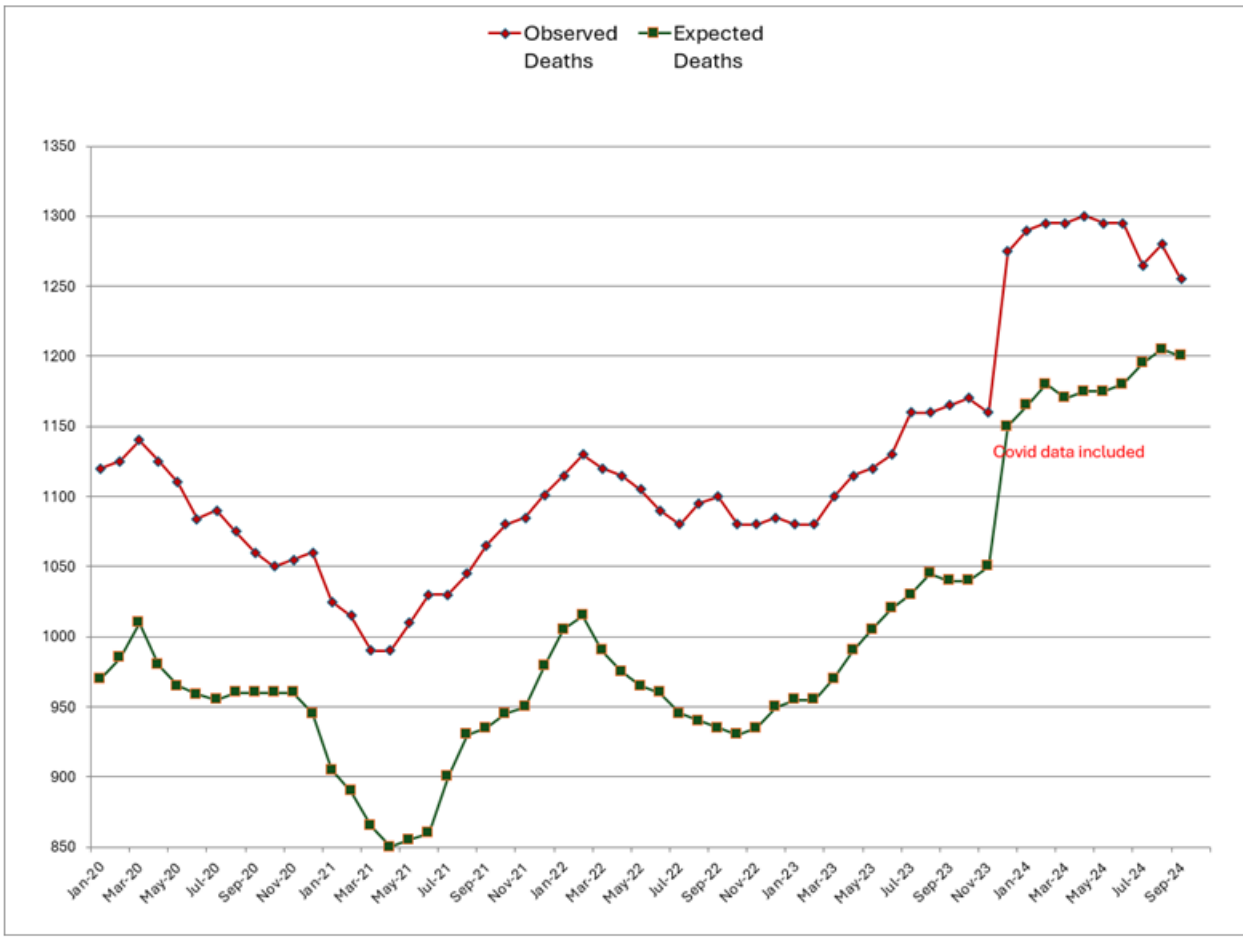
DCH % of provider spells with a primary diagnosis which is a symptom or sign is 15.9 (England average 14.4). This is similar to Q2.



2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths, the numbers of which are directly influenced by the number of in-patients.

The number of provider spells has risen again from Q2.



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Hospital Mortality Group continues to meet on a monthly basis to examine any other data which might indicate changes in standards of care. The following sections report data available from various national bodies which report on Trusts' individual performance.

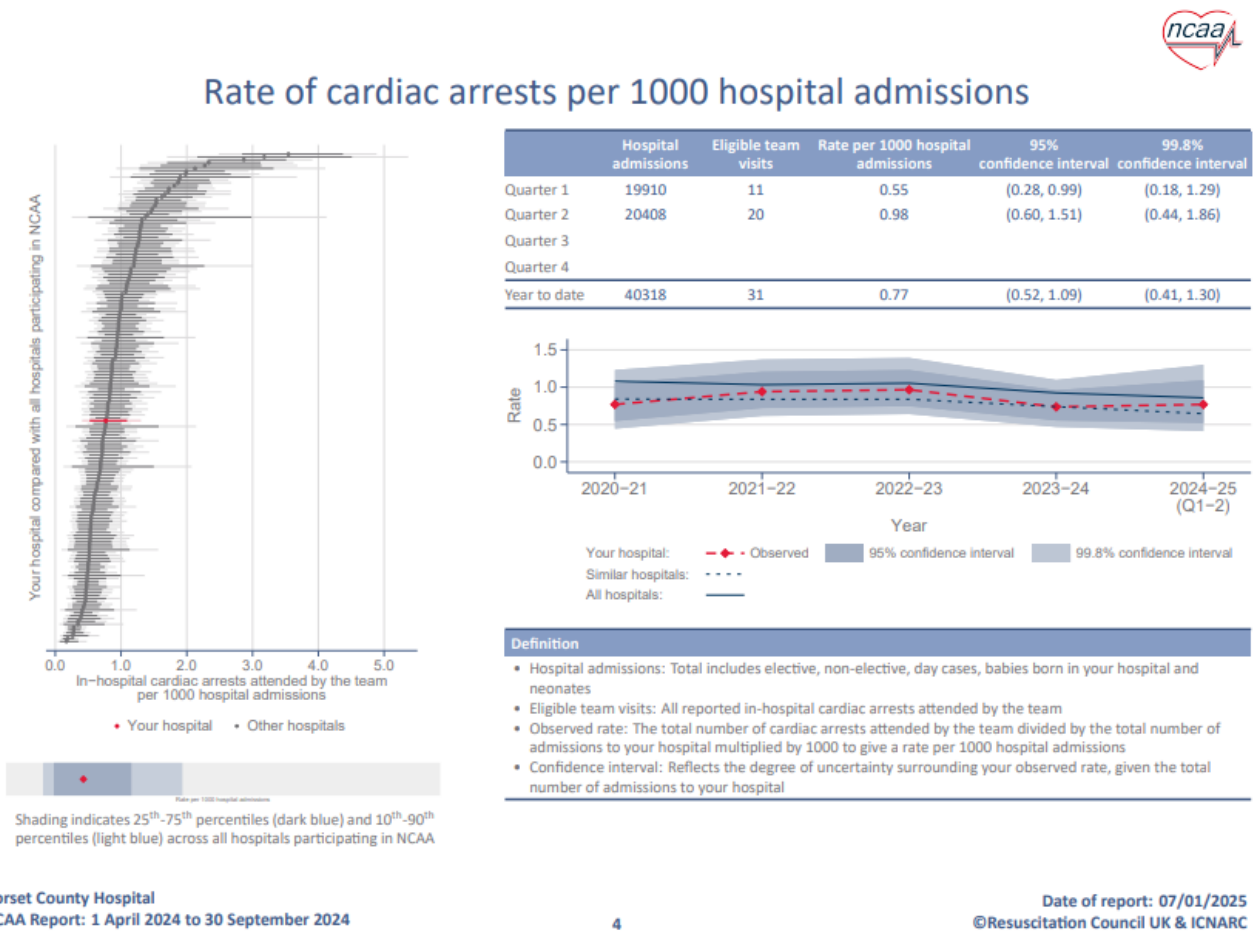
For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

In light of various issues related to maternity units and excess deaths of both children and mothers, NHS Digital has now published the first iterations of a "National Maternity Dashboard". This data is also contained within the monthly Quality report.

3.1 NCAA Cardiac Arrest data

The latest national Cardiac Arrest audit for DCH includes data from 1 April 2024 to 30 Sep 2024 & was published on 07/01/25. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven.

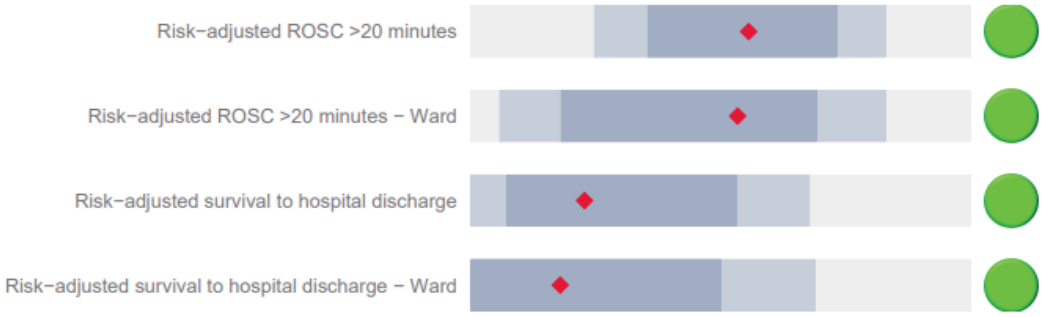
The graph below (left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year.



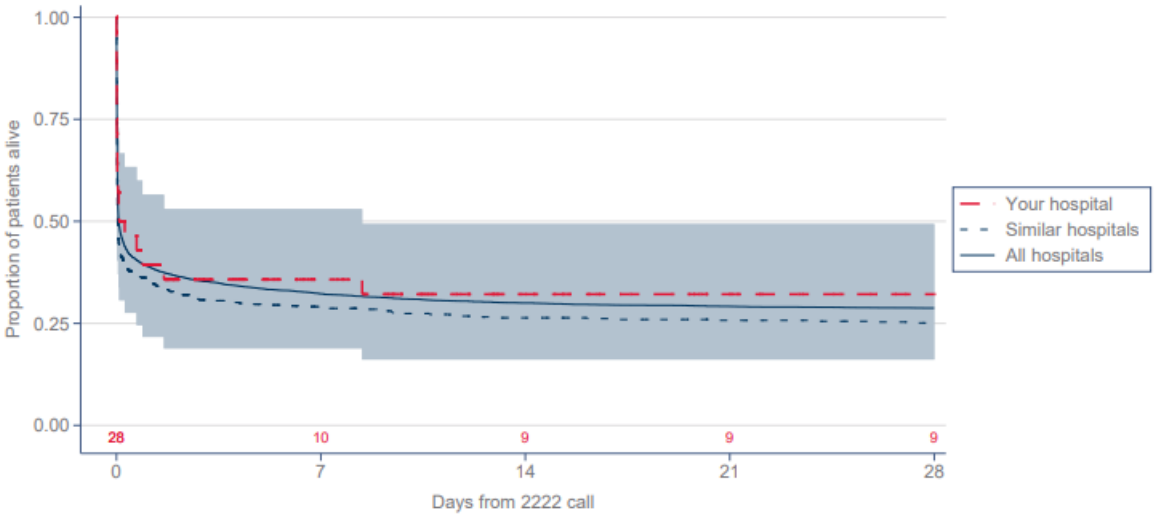
The dashboard below shows two important risk-adjusted outcome measures arising from a cardiac arrest:

a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator.

Risk-adjusted outcomes: Dashboard



Overall 28-day in-hospital survival (K-M plot)



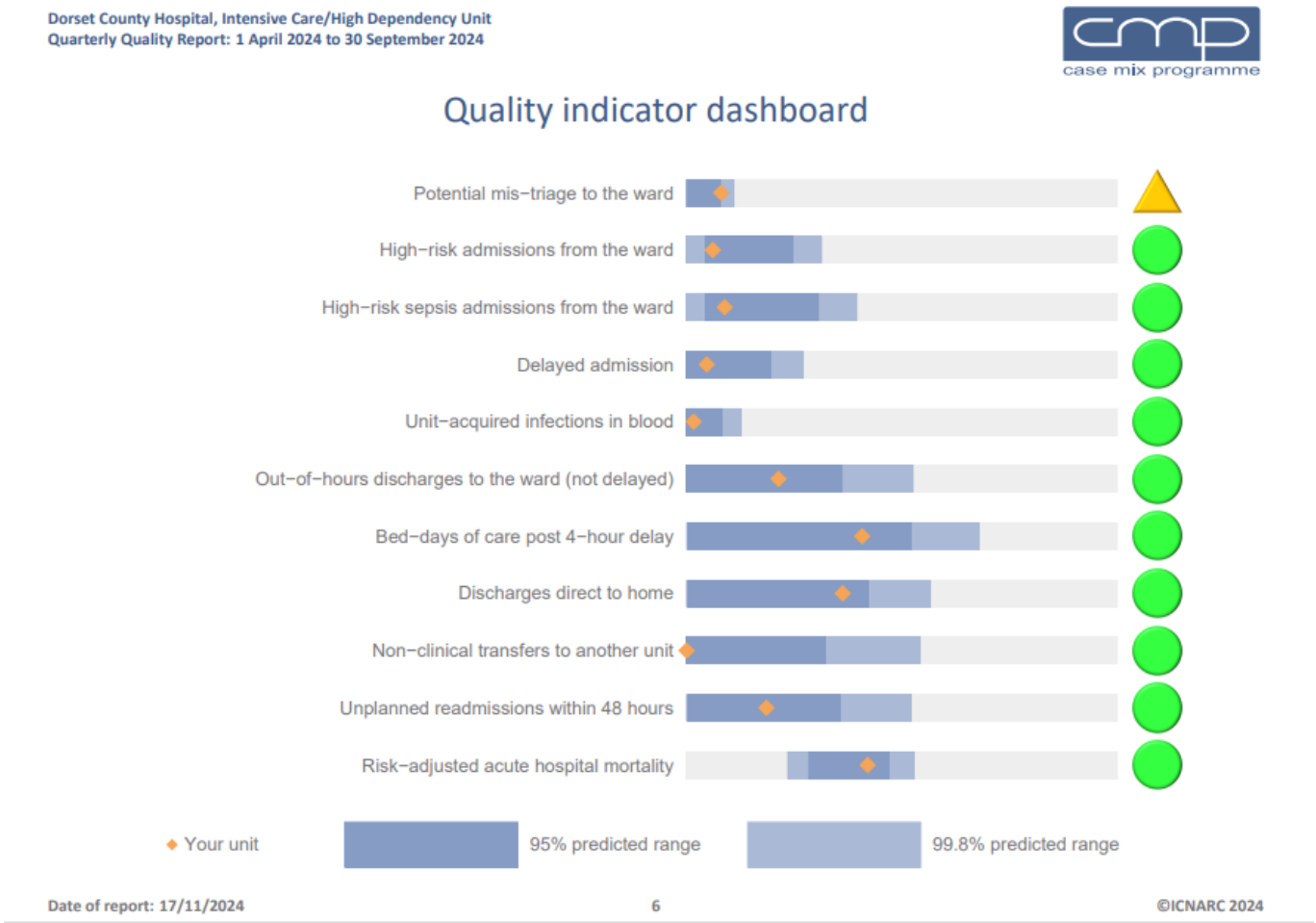
Explanation

- The Kaplan-Meier (K-M) plot shows the proportion of patients that remain alive by the number of days following 2222 call
- The shaded area shows a 95% confidence interval around the line for your hospital
- The numbers in red at the foot of the figure are the numbers of patients that have not died or been lost to follow-up for your hospital at that time point
- Patients discharged from your hospital before 28 days are assumed to have survived to 28 days

3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 but it is unclear whether this has completed.

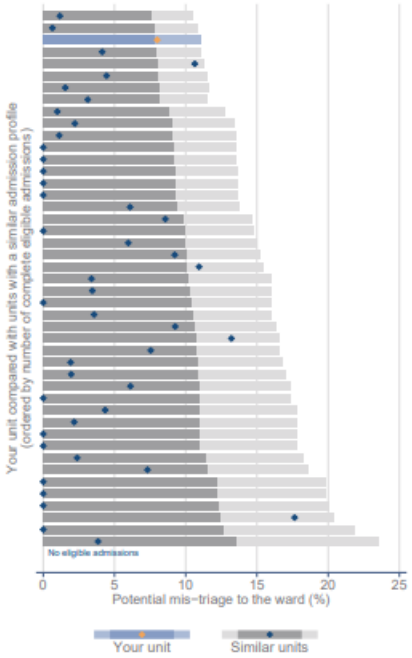
3.3 ICNARC Intensive Care survival data for Q2 dates 1 April 24 - 30 Sep 24 published Nov 2024

All but 1 of the indicators remain in the GREEN area. Potential mis-triage to ward has previously been 'green', thus awaiting results for next quarterly publication.

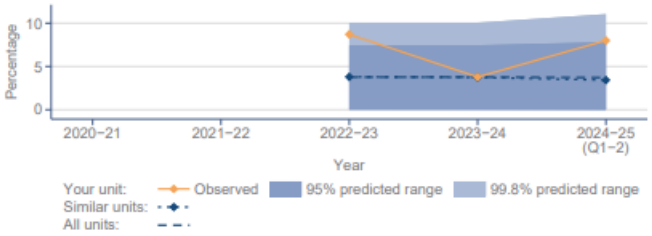


case mix programme

Potential mis-triage to the ward



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	74	74 (100.0)	●	7 (9.5)	3.8	(0.0, 8.9)	(0.0, 13.3)	▲
Quarter 2	76	76 (100.0)	●	5 (6.6)	3.3	(0.0, 7.3)	(0.0, 10.5)	●
Quarter 3								
Quarter 4								
Year to date	150	150 (100.0)	●	12 (8.0)	3.7	(0.0, 7.8)	(0.0, 11.0)	▲



Definition

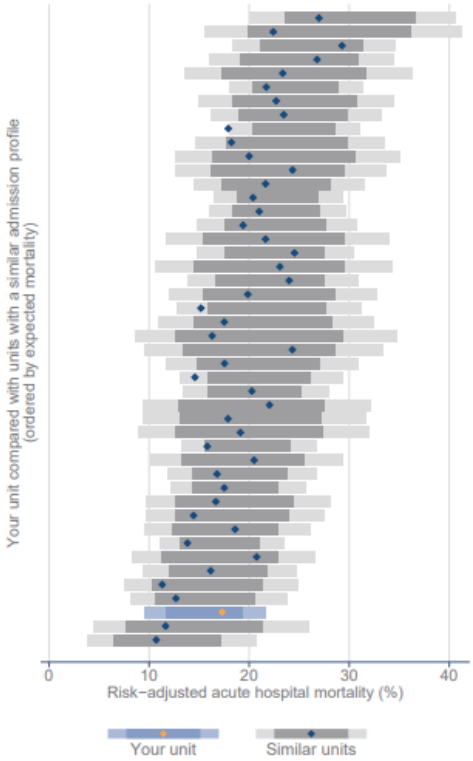
- Eligible: Unplanned critical care unit admissions, admitted to your hospital via your ED, and admitted to critical care within 8 hours of admission to hospital, excluding admissions from theatre or critical care
- Complete: The number and percentage of eligible admissions with complete data for hospital/unit admission
- Observed percentage: The number and percentage of complete eligible admissions from a ward (or intermediate care or obstetrics)
- Expected percentage: The overall percentage of potential mis-triage to the ward across all critical care units participating in the CMP
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000
- This QI is only available from version 4.0 onwards

The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.

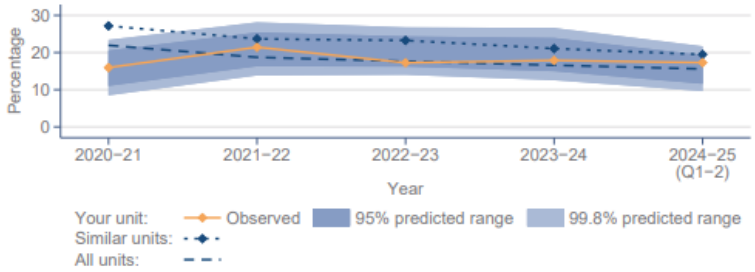
These results are well within the expected range.

case mix programme

Risk-adjusted acute hospital mortality



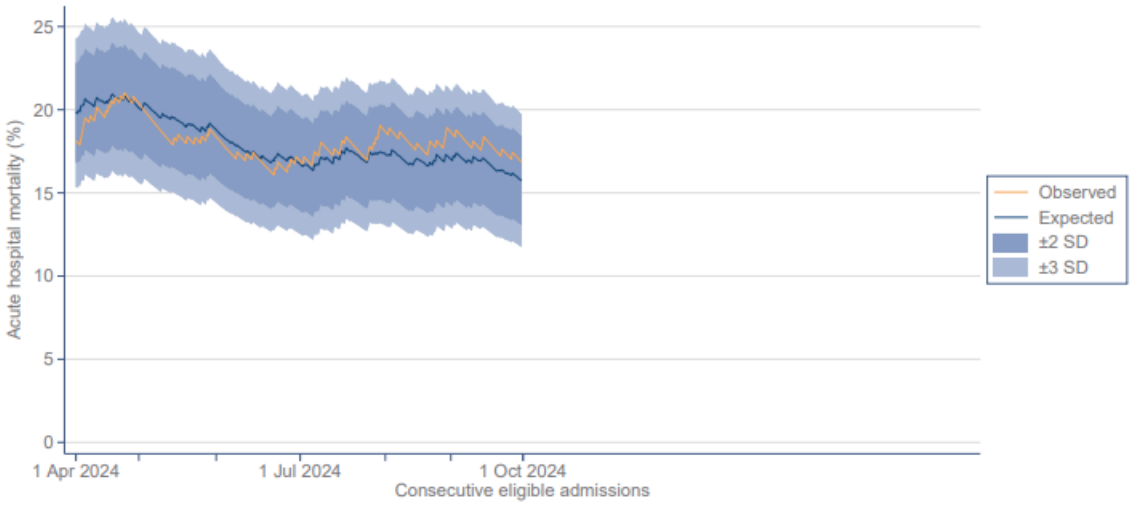
	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	171	171 (100.0)	●	29 (17.0)	15.4	(9.9, 20.7)	(7.2, 24.2)	●
Quarter 2	172	170 (98.8)	●	30 (17.6)	15.7	(10.1, 21.0)	(7.4, 24.5)	●
Quarter 3								
Quarter 4								
Year to date	343	341 (99.4)	●	59 (17.3)	15.5	(11.6, 19.3)	(9.6, 21.7)	●



Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Complete: The number and percentage of eligible admissions with sufficient data to calculate an ICNARC$_{H-2023}$ model risk prediction and complete status at discharge from acute hospital
- Observed percentage: The number and percentage of complete eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths, calculated as the mean predicted risk of death from the ICNARC$_{H-2023}$ model, among complete eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Risk-adjusted acute hospital mortality (EWMA plot)

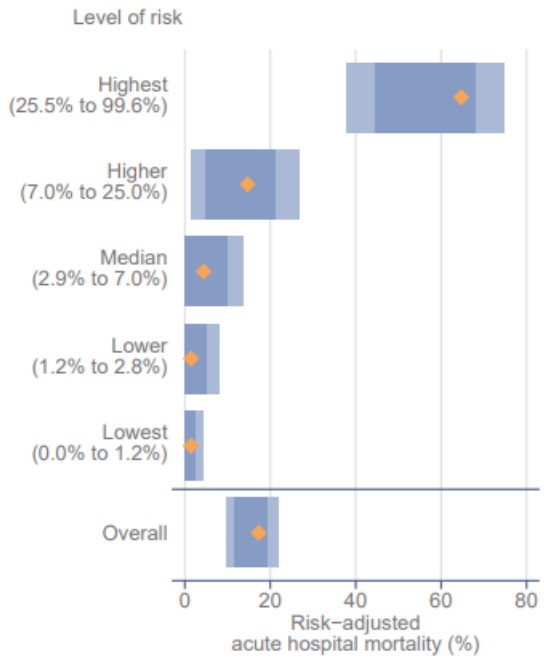


Explanation

- The Exponentially Weighted Moving Average (EWMA) plot shows the trends in observed and expected acute hospital mortality in your unit for the time period of the report
- Expected acute hospital mortality is calculated from the ICNARC$_{H-2023}$ model
- The plots are updated after each consecutive eligible admission and points are 'exponentially weighted' – giving a larger weighting to the most recent admissions to smooth the appearance of the lines
- The blue shaded areas of the plot represent 2 and 3 standard deviations (SD) above and below the expected line
- If the observed line is above the blue shaded areas, this means the observed acute hospital mortality is significantly higher than expected
- If the observed line is below the blue shaded areas, this means the observed acute hospital mortality is significantly lower than expected

case mix programme

Risk-adjusted acute hospital mortality (by predicted risk)



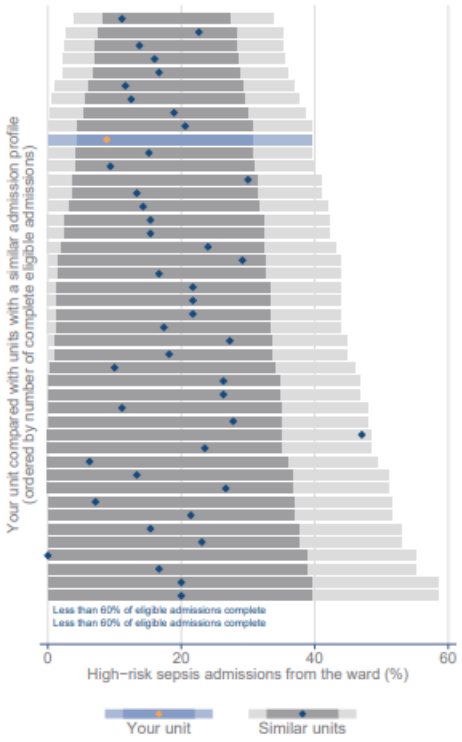
Level of risk	N	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Highest	68	44 (64.7)	57.3	(44.6, 68.2)	(37.8, 74.7)	
Higher	68	10 (14.7)	13.4	(5.0, 21.3)	(1.6, 26.8)	
Median	68	3 (4.4)	4.7	(0.0, 9.7)	(0.0, 13.7)	
Lower	68	1 (1.5)	1.9	(0.0, 5.0)	(0.0, 8.0)	
Lowest	69	1 (1.4)	0.6	(0.0, 2.4)	(0.0, 4.3)	
Overall	341	59 (17.3)	15.5	(11.6, 19.3)	(9.6, 21.7)	

Explanation

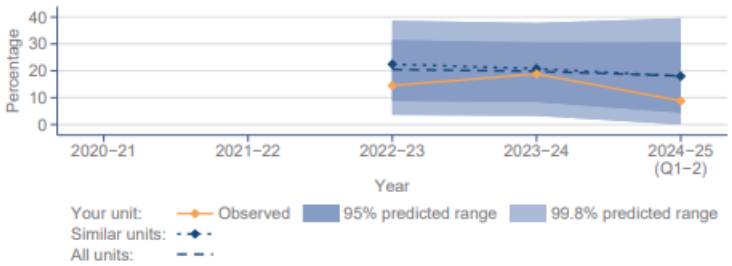
- Risk-adjusted acute hospital mortality (by predicted risk) is designed to help identify patient subgroups in which acute hospital mortality is higher (or lower) than expected
- Admissions are divided into 5 equal-sized groups (or 3 if fewer than 250 complete eligible admissions are available), according to their predicted risk of acute hospital mortality
- N is the number of complete eligible admissions (see Risk-adjusted acute hospital mortality)
- Predicted acute hospital mortality is calculated from the ICNARC$_{H-2023}$ model
- If observed acute hospital mortality is higher than predicted overall, then this analysis may help to identify patient subgroups driving that elevation; if acute hospital mortality is within the predicted range overall, then this analysis may still identify subgroups in which mortality is higher or lower than expected

case mix programme

High-risk sepsis admissions from the ward



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	18	18 (100.0)	●	0 (0.0)	18.5	(0.0, 35.6)	(0.0, 48.5)	●
Quarter 2	16	16 (100.0)	●	3 (18.8)	17.0	(0.0, 34.6)	(0.0, 48.2)	●
Quarter 3								
Quarter 4								
Year to date	34	34 (100.0)	●	3 (8.8)	18.1	(4.4, 30.6)	(0.0, 39.6)	●

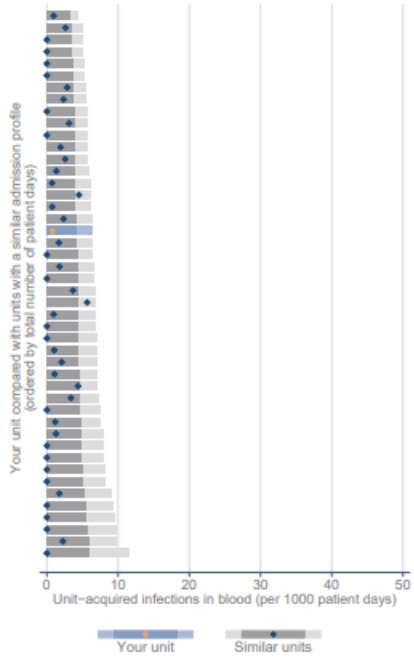


Your unit: Observed 95% predicted range 99.8% predicted range
Similar units:
All units:

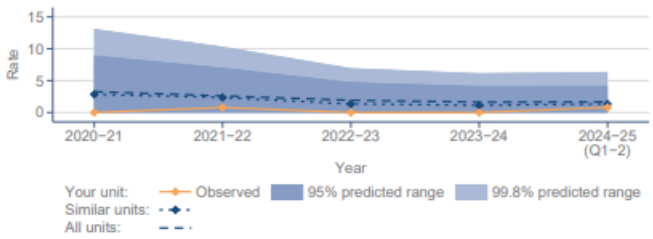
Definition

- Eligible: Critical care unit admissions with infection from a ward (or an emergency admissions unit or intermediate care) in your hospital, excluding obstetric and paediatric admissions
- Complete: The number and percentage of eligible admissions with complete data for in-hospital observations prior to referral for critical care expertise
- Observed percentage: The number and percentage of complete eligible admissions with a National Early Warning Score (NEWS2) prior to admission of 10 or more
- Expected percentage: The overall percentage of high-risk sepsis admissions from the ward across all critical care units participating in the CMP
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000
- This QI is only available from version 4.0 onwards

Unit-acquired infections in blood



	Eligible n	Complete n (rate)	Observed n (rate)	Expected rate	95% predicted range	99.8% predicted range
Quarter 1	95	95 (100.0)	0 (0.0)	1.7	(0.0, 5.0)	(0.0, 8.4)
Quarter 2	92	92 (100.0)	1 (1.5)	1.5	(0.0, 4.3)	(0.0, 7.2)
Quarter 3						
Quarter 4						
Year to date	187	187 (100.0)	1 (0.8)	1.7	(0.0, 4.1)	(0.0, 6.4)



Definition

- Eligible: Critical care unit admissions staying more than 48 hours
- Complete: The number and percentage of eligible admissions with complete data for unit-acquired infection
- Observed rate: The number of admissions with presence of infection in any blood sample taken for microbiological culture after 48 hours following admission and rate per 1000 patient days (number of admissions divided by the total number of patient days that complete eligible admissions stayed in the critical care unit, multiplied by 1000)
- Expected rate: The overall rate of unit-acquired infections in blood per 1000 patient days across all critical care units participating in the CMP
- Predicted range: We expect a unit's observed rate to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

3.4 National Hip Fracture database

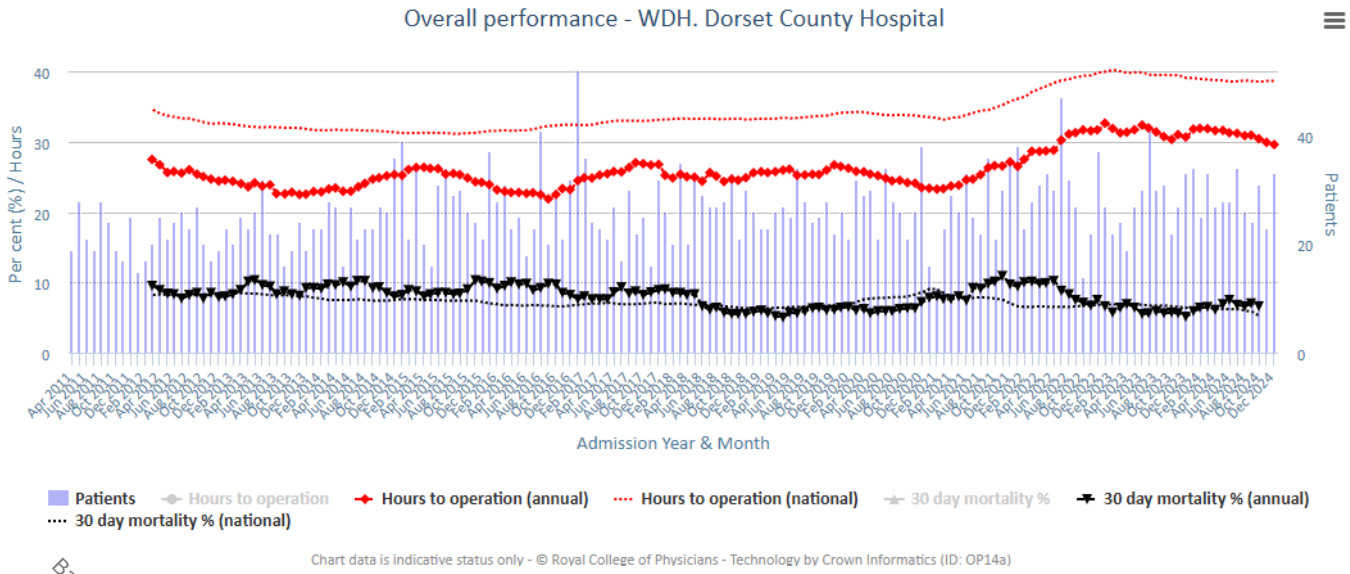
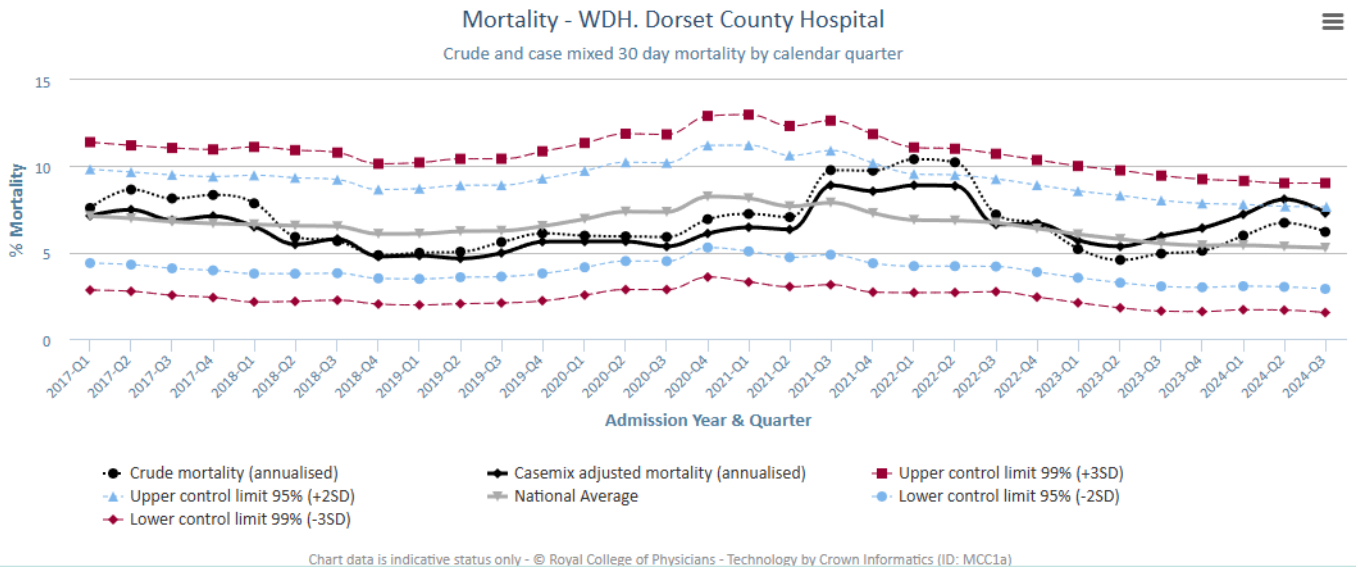


Chart data is indicative status only - © Royal College of Physicians - Technology by Crown Informatics (ID: OP14a)

Baker, Abi
02/04/2025 16:28:00

'Hours to operation' remains significantly better than the national average with 30 day mortality in line with the national average. The trauma lead and trauma coordinators are looking into the mortality data which is now plotting just above the national average. Data quality was an issue the last time this occurred but we are obviously keen to understand the trend better.



3.5 National Emergency Laparotomy Audit

Patients admitted to hospital because of an acute abdominal problem will usually undergo an urgent abdominal CT scan in order to arrive at a diagnosis. They may then need a general anaesthetic and an 'emergency laparotomy' (open abdominal surgical exploration) to resolve the underlying problem. These are high risk procedures since time to optimise the patient's condition may not be available if deterioration is occurring.

Lingering issues exist within website and some incomplete data mean that there is no new information of relevance to mortality.

3.6 Getting it Right First Time

Since the last LfD report, the following reviews have been conducted via GIRFT / external organisations:

- Virtual Wards Peer Review DCH DHC & UHD 15.10.25

The following action plans for GIRFT reviews were presented to the Clinical Effectiveness Committee in Qtr3

- TB Services

3.7 Trauma Audit and Research Network

DCH is a designated Major Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published whilst awaiting the recreation of the website.

3.8 Readmission to hospital within 30 days

A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process.

Following concerns regarding data accuracy, validation work is complete with the creation of a new dashboard to monitor both re-admission but more importantly quality aspects around re-admission with potential QI opportunity.

No new data.

3.9 National Child Mortality Database

The National Child Mortality Database (NCMD) was launched on 1 April 2019 and collates data collected by Child Death Overview Panels (CDOPs) in England from reviews of all children who die at any time after birth and before their 18th birthday.

NCMD have released data for 2024, which covers child deaths notified and reviewed up until 31 March 2024. https://www.ncmd.info/publications/child-death-review-data-release-2024/

SW estimated child death rate per 100 000 is 24.2 compared to England 29.8. Deprivation and ethnicity continue to have an impact on mortality rates.
Deaths of infants (babies under 1 year of age) accounted for 61% of all child deaths in the year ending 31 March 2024. Estimated infant death rate per 1000 live births was 3.1 for SW region (3.9 England).
Neonatal deaths (deaths of babies under 28 days of age) accounted for 42% of all child deaths in the year ending 31 March 2024. The estimated neonatal death rate for babies born at 24 weeks or over was 1.6 deaths per 1,000 live births of babies born at 24 weeks or over. The neonatal mortality rate ambition is to reduce to 1.0 deaths per 1,000 live births of babies born at 24 weeks or over, by 2025.

DCH is submitting its response to the following national reports:

i) *Learning from deaths of children with a learning disability and autistic children.* Action identified: Flagging for LD or ASD is available on PAS- LD Lead or LD acute Health Facilitator can add once CYP is identified and consent given. Paediatric Reasonable adjustment care plan/ This is Me My Care Passport form part of policy. There are LDA Champions/ Advocates within the Trust. Was Not Brought (WNB) policy recently updated to support effective attendance.

ii) *Child deaths due to asthma or anaphylaxis.* Action identified: Increase awareness of Asthma (Children and young people) - elearning for healthcare amongst DCH staff caring for CYP with asthma via newsletter / email / staff meetings. CPD monitored at appraisal.

Responses will be available on sharepoint in due course.

Pan Dorset & Somerset CDOP continues to review cases and share learning as appropriate. CDOP is planning a learning event in March 2025 for professionals from all agencies.

PanDorset and Somerset CDOP annual report for 1 April 2023 – 31 March 2024 was presented to the PanDorset Mortality Surveillance Group Feb 2025. Over the past 4 years, the most common category of child death was perinatal / neonatal event followed by chromosomal, genetic, and congenital anomalies.
52% (14/27 reviewed) of deaths had modifiable factors identified. Modifiable factors do not mean that deaths were necessarily preventable. Since 1 April 2024 the panel are having specific focussed case discussions on modifiability with consistent definition applied that is aligned to other CDOPs regionally. Modifiable factors are those which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths. An example of a modifiable factor is smoking in pregnancy when the categorisation of death is recorded as extreme prematurity. We would expect the number of cases with modifiable factors to fall in line with regional peers next year.

NCMD report identified the most common recorded modifiable factors by CDOPs during reviews of infant deaths were smoking by a parent/carer, high maternal body mass index (BMI) and smoking in pregnancy. For deaths of children aged 1 – 17 years factors were poor communication between agencies, 12% of child death reviews (1 – 17 years) with categorised modifiable factors, 4% of all child death reviews (1 – 17 years)), issues with treatment (e.g., delay in starting treatment, side effects or complications developed as a result of treatment, or medical or surgical error) (9%, 3%) and lack of appropriate supervision (e.g., young child unsupervised in a bath) (9%, 3%).

Examples of learning from CDOP reviews include:

- New processes to improve CTG interpretation in maternity
- New parental / guardian self discharge process in ED (East Dorset) & improved paediatric nursing in ED
- Best management of CYP with complex long term health conditions & palliative care
- Enhanced maternity care pathways when parental cannabis identified
- Consistency in care when sensitively viewing deceased children
- Educational update from Police regarding drug use amongst CYP
- Concern re suicide rates in 15-17yr olds across Dorset (higher than national average) -with focus with schools on suicide prevention

3.10 **MBRRACE** data:

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU

The maternity and neonatal teams at DCH use the BAPM Perinatal Optimisation Pathway to support improving outcomes for preterm babies. Compliance with PERIPrem is monitored at Perinatal M&M meetings when presenting cases.
https://www.bapm.org/pages/perinatal-optimisation-pathway
https://www.healthinnowest.net/our-work/transforming-services-and-systems/periprem/

No new reports / data for Q3

3.11 National Perinatal Mortality Review tool

Reports | PMRT | NPEU

Data included in the Maternity safety report to Quality Committee in line with Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) standards.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

The following themes have been identified from SJRs / discussions at HMG with some being translated into quality improvement projects:

1. Management of backlog of SJR in Division A
2. Mortality Review policy update complete
3. Update to TEP / DNAR policy almost complete.

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Dates of these meetings are reported to and reviewed by the Divisional Clinical Governance meetings. Following M&M meetings any learning and actions identified from the cases discussed are highlighted and information collated on an overview slide which is shared at their monthly Care Group meeting and the Divisional

Business & Quality Governance meeting. Records of action plans and learning identified are available across departments.

Examples of Learning and Actions from M&M Meetings:

- Reminder of the benefits of performing a Facia Iliaca Block (FIB) in patients with fractured NOF.
- Reminder - Early antibiotics reduces mortality in patients with sepsis.
- For each note entry – a reminder to write date and time as well as signing and printing name.
- A patient waited 5 days for a PICC line for TPN – growing evidence for the need for a funded Trust Vascular Access Service.
- Patient with severe dementia and hoist transfer with community DNAR – This was continued on admission but no TEP form was completed. Please remember to complete TEP when writing or re-writing a DNAR form.
- Excellent practice of MDT discussions around high-risk cases between consultant surgeons and anaesthetists
- Paediatric Asthma/Wheeze pathways – PIER vs SORT. PIER doesn't consider next steps eg. IV MgSO4/aminophylline. This will be reviewed by the PIER team
- Challenges of outdated documents being uploaded onto DPR. Need to ensure we are using the most up to date version of care plans/ACPs etc.
- Raising staff awareness of where to access rarely used emergency drugs (e.g. for inborn errors of metabolism)
- Good escalation of persistent tachycardia and hypotension. Especially in light of patient looking well and stating they felt 'fine'. Fresh eyes reviews helped identify subtle changes to physiology and enable escalation.
- Challenges of obtaining CTA in possible paediatric stroke presentation.
- How do we ensure junior staff can speak openly about management and concerns they may have? Agreement from members that it is acceptable for a junior staff member to contact the Consultant if they have patient and/or staff safety concerns.
- Discussions around restraint and update training.
- Rescue analgesia important. EPMA bundles eg paediatric and adult protocols are available which include pre-med, post op analgesia and antiemetics and TTAs and should be used where possible, when not possible ensure other recovery medication is prescribed.
- Reminder to ensure any unit of a blood product not intended to be given immediately is refrigerated or returned to blood bank to avoid waste.
- Reminder to consider reason for anaemia before transfusing, especially if haemodynamically stable.
- Patient should not be transferred until recovery criteria met unless specifically agreed by anaesthetist or critical care practitioner

- Examples across the Trust of good MDT & family involvement in decisions around conservative management and palliative care.

6.0 LEARNING FROM CORONER'S INQUESTS Q3

DCH has been notified of **16** new Coroner's inquests being opened in the period 01 October 2024 – 31 December 2024. We have seen a huge increase in the complexity of the cases.

28 inquests were held during Quarter 3. **21** inquests were heard as Documentary hearings, not requiring DCH attendance. **6** required a clinician to attend court in person. **1** inquest was held hybrid (some clinicians attending remotely, whilst others attended in person).

2 pre-Inquest review hearings were held.

We currently have **56** open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No Regulation 28 (Preventive Future Death Notices) have been given during this quarter, and we have not required Representation.

We continue to work with the Coroner's office, and will continue to support staff before, during and after these hearings. The coroner requested that from May 2022 witnesses should attend the court room at the Town Hall, Bournemouth in person. Authority is now required if we wish the clinician to attend remotely.

Clinical Leads have been attending inquests to ensure there is some resilience within the Risk Team.

Learning Identified:

- Improved communication with family about outcomes for elderly patients requiring hip surgery i.e.risks of mortality, when counselling regarding such surgery to the nok as well as elderly patients.
- Improved communication with families around discharge to residential settings, not just the Trusted Assessor (TA).
- Update TA when discharge dates change.

Record significant treatment eg blood transfusion in discharge summaries

7.0 LEARNING FROM CLAIMS Q3

Legal claims are facilitated by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. The GIRFT pack for this year has been released, but we identified errors with the data provided. This was highlighted to the national GIRFT team, and they have confirmed that there has been an error with the data stream going into the litigation data packs which they will need to re-validate and then re-share.

Claims pattern Quarter 3 FY 24/25.

New potential claims	17 clinical negligence, 1 employee
Disclosed patient records	36 (19 disclosure for claims inc updated records, 17 disclosures to the coroner)
Formal claims	11 clinical negligence, 2 employee claim
Settled claims	3 clinical negligence, 0 employee claims (Delay in treatment, Consent, Incorrect treatment)
Closed - no damages	1 clinical negligence, 0 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period 1 May 2023 – 30 Sep2024. The Trust's figure continues to fall as predicted and is now at its lowest for a significant period at 1.043. This is within the expected range using NHS England's control limits.

We are aware that our data may in future become adversely influenced by resource challenges within the Coding Department and a possible under-reporting of 'sepsis' in the written medical record. The clinical coding risk is rated as high on the risk register. The team have implemented strategies for risk mitigation.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH. Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings, Medical Examiners and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Further work in progress to support more appropriate identification of those deaths requiring SJR & to facilitate timely completion of SJR within division A.

Dorset County Hospital
Dorset HealthCare

Report to	DCH and DHC Board of Directors	
Date of Meeting	8 April 2025 9 April 2025	
Report Title	Quality Committee in Common Terms of Reference and creation of Mental Health Legislation Committee in Common	
Prepared By	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	25 March 2025 – DCH Quality Committee 26 March 2025 – DHC Quality Governance Committee 26 March 2025 – Strategy Transformation and Partnerships Committee in Common	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	*SR1 Safety and Quality*	
Financial	No specific implications arising from this report	
Statutory & Regulatory	Statutory and regulatory reporting built into TOR	
Equality, Diversity & Inclusion	No specific implications arising from this report	
Co-production & Partnership	No specific implications arising from this report	

Executive Summary

- It was agreed that we would move to Committee in Common across three areas, but the Quality Committee in Common would be reviewed with an intention, if ready, to move to a Quality Committee in Common across DCH and DHC in Q4 of 2024/25 at the earliest.

- The respective Quality Committees and the Strategy, Transformation and Partnerships Committee-in-Common (as the Committee with oversight of the 'Working Together Programme') agreed at their January 2025 meetings that we should move to a Quality Committee in Common from Q1 of 25/26. The scope of the new Committee was agreed at the January 2025 meetings and the Terms of Reference were presented for approval by the respective Committees in March 2025. An annual programme of work is being developed for the Quality Committee in Common and this will be presented to the first meeting of the Committee in Common, together with a transition plan to provide assurance that all outstanding actions have been captured.

- In recognition of the increased scope of the Committee (to incorporate DCH and DHC) it is now proposed that the DHC Mental Health Legislation Assurance Committee (MHLAC) is re-formed as Board level Committee. DCH have a separate Mental Health Legislation Steering Group. As responsibility for mental health legislation is being removed from the Quality Committee there is an option to create a Mental Health Legislation Committee in Common across DCH and DHC.

- The respective Quality / Quality Governance Committees approved the Terms of Reference and supported the creation of a Mental Health legislation Committee in Common. The Strategy, Transformation and Partnerships Committee (as the Committee with oversight of the Working Together Programme) also supported this approach.

- Following discussion at Committee, and subsequent at Joint Executive Management Team, it is proposed that health inequalities and the Patient and Carer Race Equality Framework (PCREF) will move from the Strategy, Transformation and Partnerships Committee and the appended TOT have been updated to reflect this.

Recommendation

The Board of Director is requested to:

- Approve the Terms of Reference for the Dorset Quality Committee in Common
- Approve the creation a Mental Health Legislation Committee in Common

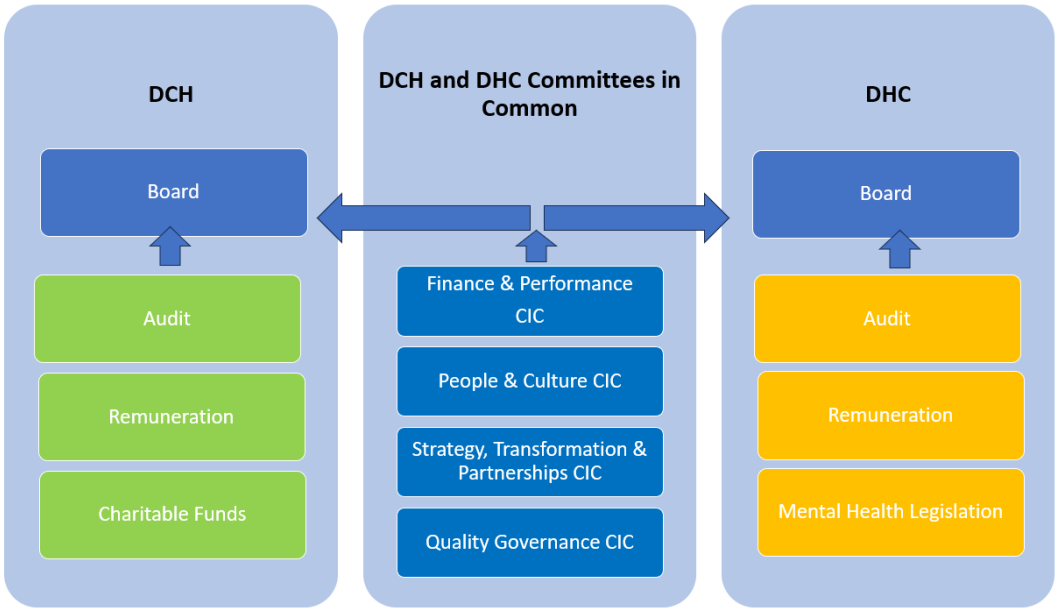
Approval of Quality Committee in Common Terms of Reference and creation of Mental Health Legislation Committee in Common

1. Board Subcommittee Review

1.1 Following the appointment of joint Chair and joint Chief Executive Officer, and the establishment of the Working Together Committee in Common (CiC) and Programme Board, a review of the governance arrangements across Dorset County Hospital (DCH) and Dorset Healthcare (DHC) was commissioned to promote collaboration across the activities of Boards and their committees in both trusts, reduce duplication and to identify areas of shared learning.

1.2 On 31 January 2024 / 7 February 2024 the Boards of DCH and DHC respectively considered the outcomes of that governance review and determined that: they endorsed the recommendation from the Working Together Programme Committee in Committee and formally agreed to approve Option 3 - to implement a combination of joint Board subcommittees with Dorset County Hospitals and Trust only committees.

1.3 The Working Together Committee in Common approved the creation of four Committees in Common as set out in the diagram below at its meeting on 3 June 2024:



1.4 It was agreed that we would move to Committee in Common across three areas, but the Quality Committee in Common would be reviewed with an intention, if ready, to move to a Quality Committee in Common across DCH and DHC in Q4 of 2024/25 at the earliest.

1.5 Preparations for this have continued during Q3 and Q4. This has included a group that has come together to review and align the workplans for the Committee. The respective Quality Committees and the Strategy, Transformation and Partnerships Committee-in-Common (as the Committee with oversight of the 'Working Together Programme') agreed at their January 2025 meetings that we should move to a Quality Committee in Common from Q1 of 25/26. The scope of the new Committee was

agreed in principle at these meetings and the Terms of Reference for the new Committee in Common have now been developed.

1.6 In recognition of the increased scope of the Committee (to incorporate DCH and DHC) it is now proposed that the DHC Mental Health Legislation Assurance Committee (MHLAC) is re-formed as Board level Committee. Whilst the reporting line would be elevated in the governance structure this Committee already has non-executive membership.

1.7 DCH have a separate Mental Health Legislation Steering Group. As responsibility for mental health legislation is being removed from the Quality Committee there is an option to create a Mental Health Legislation Committee in Common across DCH and DHC. This would strengthen the oversight of the application of mental health legislation in DCH. In addition, the administration of mental health legislation is provided by DHC to DCH under a Service level Agreement (SLA) and a DCH NED already attends the DHC Mental. The Committee is therefore asked to endorse the creation of a Mental Health Legislation Committee in Common across DCH and DHC.

1.8 The respective Quality / Quality Governance Committees approved the Terms of Reference and supported the creation of a Mental Health legislation Committee in Common. The Strategy, Transformation and Partnerships Committee (as the Committee with oversight of the Working Together Programme) also supported this.

1.9 An annual programme of work is being developed for the Quality Committee in Common and this will be presented to the first meeting of the Committee in Common, together with a transition plan to provide assurance that all outstanding actions have been captured.

2. Terms of Reference – Quality Committee in Common

2.1 The Quality Committee in Common Terms of Reference have been reviewed. A full comparison was undertaken and this was considered by the respective Committees. The new Terms of Reference are included at Appendix A.- there is a Terms of Reference for each Trust. These terms of reference are a mirror of each other.

2.2 Legal advice has been sought from Hill Dickinson LLP on the Terms of Reference to ensure that the technical aspects of operating a Committee in Common are adhered to.

2.3 It has previously been agreed that NED Membership for each organisation on each Committee will be two members. However, learning from the other Committees in Common has been that this may not be sufficient, and it is proposed for this Committee that there will be three NED members from each Trust (recognising that one or more NEDS could be a 'joint' NED and therefore representing DCH and DHC.

2.4 Following discussion at Committee, and subsequent at Joint Executive Management Team, it is proposed that health inequalities and the Patient and Carer Race Equality Framework (PCREF) will move from the Strategy, Transformation and Partnerships Committee and the appended TOT have been updated to reflect this.

2.4 The workplans for each Committee will be reviewed and presented to the first meeting of each Committee in Common. A transition plan is being developed to ensure that

that all actions are either closed or transferred to the new Committee and that all areas are covered as we transition to new Committee Terms of Reference.

2. Recommendation

The Board of Director is requested to:

- Approve the Terms of Reference for the Dorset Quality Committee in Common
- Approve the creation a Mental Health Legislation Committee in Common

Dorset County NHS Foundation Trust Quality Committee-in-Common TERMS OF REFERENCE	
Committees in Common	• The Dorset County NHS Foundation Trust ('Dorset County Hospital) is putting in place a governance structure, which will enable it to work together with the Dorset Healthcare University NHS Foundation Trust ('Dorset healthcare'). • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare as the **Dorset Trust Quality CiCs**
Responsibilities	• The Committee-in-Common has been established by the Board of Dorset County Hospital NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital Quality CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Quality CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital Quality CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital Quality CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital Quality CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Quality CiC. • The Dorset County Hospital Quality CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital Quality CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution. • The Quality Committee CiC will, together with the other Committees in Common, advise, support and assure the Board of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust on matters related to:

	○ Oversight of quality, safety, clinical governance and patient and carer experience on behalf of the Board. ○ Overseeing, monitoring and reviewing the governance arrangements underpinning the planning and delivery of care according to the Care Quality Commission's (CQC) key lines of enquiry for assessing healthcare services. ▪ Are they safe? ▪ Are they effective? ▪ Are they caring? ▪ Are they responsive? ▪ Are they well-led?
Responsibilities	The Dorset County Hospital Quality CiC will together with the other Committees in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: • Providing specialist advice, support and assurance to the Board on all matters relating to quality, patient and carer experience, clinical effectiveness, safety, clinical governance, clinical / operational risk and incident management. • Consider all matters which affect the quality of the service, effectiveness, experience and safety of patients. This includes work associated with the following programmes of work: a. Clinical Audit and Effectiveness b. Research and Developing c. Mortality and learning from deaths d. Patient and carers experience e. Learning from Complaints/PALs f. Learning from Incidents, including oversight of the Patient Safety Incident Response Framework (PSIRF) g. Infection Prevention and Control h. Drugs, Therapeutics and non-medical prescribing i. Violence and Personal Safety j. Restrictive interventions k. Safeguarding l. Learning arising from claims and inquests m. Risk Register relevant to the work of the Committee n. Compliance with CQC regulations o. Nutrition and Hydration p. Policies relating to the scope of work of the Committee q. Clinical Procedures (system and process) r. Safer staffing s. Maternity Services (DCH only) t. End of Life Care u. Health Inequalities v. Patient Carer Race Equality Framework (PCREF – DHC only) • Scrutinise assurances on a rolling programme throughout the year as to the Trust's governance arrangements being compliant with the law and with CQC registration requirements and those of other bodies that have regulatory oversight of the services and activities of the Trust. • Review and monitor compliance with new and existing statutory standards, legislative requirements and accreditation standards and will consider

	recommendations for the relative priority for implementation of guidance and the timeliness of implementation. • Consider the development of systems of governance to monitor standards and outcomes of care, including benchmarking schemes and indicators, including non-clinical indicators that impact on clinical care. • Consider quality and clinical governance implications to the Trust of the findings and reports of regulatory, professional and independent bodies such as (but not limited to) Care Quality Commission, NHS Improvement, Royal Colleges, etc. • Review, scrutinise and challenge clinical action plans to address failing targets and / or poor quality or safety matters. • Consider and review the outcome of quality impact assessments which arise from service redesign and Cost Improvement Plans (CIP) and which may adversely impact upon quality and safety. • Consider and agree annual priorities for quality and approve the Trust's Annual Quality Account prior to ratification by the Trust Board. • Approve Statutory Annual Reports for Safeguarding, Complaints and Infection Prevention & Control and other Annual Reports as appropriate to the business of the Committee. • Consider and approve statutory annual mixed sex accommodation declarations and any supporting action plans to address improvements. • Consider and recommend to the Board annual establishment reviews. • Receiving and approving the annual clinical audit programme prior to recommending ratification to Trust Board. • Seek assurance on behalf of the Trust Board for the response to safety and quality risks which appear on the Board Assurance Framework and Corporate Risk Register • Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements	• The Dorset County Hospital Quality CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital Quality CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**<u>Non-Executive</u>** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee

	Executive • Joint Nursing Officer • Chief Medical Officer – DCH • Chief Medical Officer - DHC • Chief Operating Officer – DCH • Chief Operating Officer - DHC **In attendance** • DHC - Director of Nursing, Therapies and Quality • DCH - Director of Nursing and Quality • Divisional/Directorate Triumvirate • Joint Deputy Director of Corporate Affairs • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Hospital Quality CiC meets with the associated committee from Dorset Healthcare University NHS Foundation Trust as committees in common (Dorset Trust Quality CiC), one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	Members of the Dorset County Hospital Quality CiC have a responsibility for the operation of the Dorset County Hospital Quality CiC. They will participate in discussion, review evidence and provide objective expert input as part of the Dorset Trust Quality CiC to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital Quality CiC shall have one vote. The Dorset County Hospital Quality CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director representing each Trust (which may include a Joint Executive Director acting for both Trusts). If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	• Administrative support will be arranged by the Corporate Affairs Directorate. • Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• Subject to the below, Dorset County Hospital Quality CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust Quality CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	• Members of the Dorset County Hospital Quality CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest

	guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Quality CiC. • All Members of the Dorset County Hospital Quality CiC shall declare any new interest at the beginning of any meeting and at any point during a meeting if relevant.
Date Approved	• Approved by Quality Committee 25th March 2025 • Ratified by Dorset County Hospital NHS Foundation Trust Board of Directors To add date
Date Review	31 March 2026

Dorset HealthCare University NHS Foundation Trust
Quality Committee-in-Common

TERMS OF REFERENCE

Committees in Common	• The Dorset HealthCare University NHS Foundation Trust ('Dorset HealthCare) is putting in place a governance structure, which will enable it to work together with the Dorset County Hospital NHS Foundation Trust. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset County NHS Foundation Trust as the **Dorset Trust Quality CiCs**
Responsibilities	• The Committee-in-Common has been established by the Board of Dorset HealthCare University NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset HealthCare Quality CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset HealthCare Quality CiC. It is supported in its work by other committees established by the Board. • The Dorset HealthCare Quality CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset HealthCare Quality CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset HealthCare Quality CiC is a committee of the Trust and therefore can only make decisions binding Dorset HealthCare University NHS Foundation Trust. None of the Trusts other than Dorset HealthCare University NHS Foundation Trust can be bound by a decision taken by Dorset HealthCare Quality CiC. • The Dorset HealthCare Quality CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset HealthCare Quality CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset HealthCare University NHS Foundation Trust's Constitution. • The Quality Committee CiC will, together with the other Committees in Common, advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related: o Oversight of quality, safety, clinical governance and patient and carer experience on behalf of the Trust Board.

	○ Overseeing, monitoring and reviewing the governance arrangements underpinning the planning and delivery of care according to the Care Quality Commission's (CQC) key lines of enquiry for assessing healthcare services. ▪ Are they safe? ▪ Are they effective? ▪ Are they caring? ▪ Are they responsive? ▪ Are they well-led?
Responsibilities	The Dorset HealthCare Quality CiC will together with the other Committees in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: • Providing specialist advice, support and assurance to the Board on all matters relating to quality, patient and carer experience, clinical effectiveness, safety, clinical governance, clinical / operational risk and incident management. • Consider all matters which affect the quality of the service, effectiveness, experience and safety of patients. This includes work associated with the following programmes of work: a. Clinical Audit and Effectiveness b. Research and Developing c. Mortality and learning from deaths d. Patient and carers experience e. Learning from Complaints/PALs f. Learning from Incidents, including oversight of the Patient Safety Incident Response Framework (PSIRF) g. Infection Prevention and Control h. Drugs, Therapeutics and non-medical prescribing i. Violence and Personal Safety j. Restrictive interventions k. Safeguarding l. Learning arising from claims and inquests m. Risk Register relevant to the work of the Committee n. Compliance with CQC regulations o. Nutrition and Hydration p. Policies relating to the scope of work of the Committee q. Clinical Procedures (system and process) r. Safer staffing s. Maternity Services (DCH only) t. End of Life Care u. Health Inequalities v. Patient and Carer Race Equality Framework (PCREF – DHC only) • Scrutinise assurances on a rolling programme throughout the year as to the Trust's governance arrangements being compliant with the law and with CQC registration requirements and those of other bodies that have regulatory oversight of the services and activities of the Trust. • Review and monitor compliance with new and existing statutory standards, legislative requirements and accreditation standards and will consider recommendations for the relative priority for implementation of guidance and the timeliness of implementation.

	• Consider the development of systems of governance to monitor standards and outcomes of care, including benchmarking schemes and indicators, including non-clinical indicators that impact on clinical care. • Consider quality and clinical governance implications to the Trust of the findings and reports of regulatory, professional and independent bodies such as (but not limited to) Care Quality Commission, NHS Improvement, Royal Colleges, etc. • Review, scrutinise and challenge clinical action plans to address failing targets and / or poor quality or safety matters. • Consider and review the outcome of quality impact assessments which arise from service redesign and Cost Improvement Plans (CIP) and which may adversely impact upon quality and safety. • Consider and agree annual priorities for quality and approve the Trust's Annual Quality Account prior to ratification by the Trust Board. • Approve Statutory Annual Reports for Safeguarding, Complaints and Infection Prevention & Control and other Annual Reports as appropriate to the business of the Committee. • Consider and approve statutory annual mixed sex accommodation declarations and any supporting action plans to address improvements. • Consider and recommend to the Board annual establishment reviews. • Receiving and approving the annual clinical audit programme prior to recommending ratification to Trust Board. • Seek assurance on behalf of the Trust Board for the response to safety and quality risks which appear on the Board Assurance Framework and Corporate Risk Register • Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements	• The Dorset HealthCare Quality CiC is accountable to the Board of Dorset HealthCare University NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset HealthCare University NHS Foundation Trust. • Dorset HealthCare Quality CiC shall provide such other reports and communications briefings as requested by Dorset HealthCare University NHS Foundation Trust's Board for inclusion on the agenda of Dorset HealthCare University NHS Foundation Trust's Board meeting.
Membership / Attendance	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **Executive** • Joint Nursing Officer • Chief Medical Officer – DCH

	• Chief Medical Officer - DHC • Chief Operating Officer – DCH • Chief Operating Officer - DHC **In attendance** • DHC - Director of Nursing, Therapies and Quality • DCH - Director of Nursing and Quality • Divisional/Directorate Triumvirate • Joint Deputy Director of Corporate Affairs • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset HealthCare Quality CiC meets with the associated committee from Dorset County NHS Foundation Trust as committees in common (Dorset Trust Quality CiC), one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	Members of the Dorset HealthCare Quality CiC have a responsibility for the operation of the Dorset HealthCare Quality CiC. They will participate in discussion, review evidence and provide objective expert input as part of the Dorset Trust Quality CiC to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset HealthCare Quality CiC shall have one vote. The Dorset HealthCare Quality CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
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	• All Members of the CiC shall declare any new interest at the beginning of the meeting and at any point during a meeting if relevant.
Date Approved	• Approved by Quality Committee 26th March 2025 • Ratified by Dorset HealthCare University NHS Foundation Trust Board of Directors To add date
Date Review	31 March 2026

Dorset County Hospital
Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Monday 24 March 2025

Chair	Dave Underwood
Executive Lead	Chris Hearn – Joint Chief Financial Officer Rachel Small – Chief Operating Officer, DHC Anita Thomas – Chief Operating Officer, DCH
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Receipt of the 2025/26 Financial and Operational Plan incl. Capital Programme, which is recommended to the Board for approval • Approval of the estates and facilities, and finance and procurement strategy enabling plans

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

DCH Finance Report
At month 11 DCH is on target to deliver the risk adjusted forecast outturn position. The YTD position is £9.4m deficit. YTD CIP delivery savings are £7.2m against a target of £14.4m. YTD agency expenditure is £6.1m which is a significant improvement compared to same period last year. The month 11 cash position is £11.8m.

DHC Finance Report
The £1.3m planned year-end surplus position will likely be achieved. YTD overall agency expenditure is £1.5million less than the same period last year, but YTD Medical agency expenditure is £500k more than same period last year. £17.47m of the £19.15m savings requirement has been confirmed and removed from budgets, equating to 91% of the target. Significant cost pressure in out of area placements.

2025/26 Financial and Operational Plan incl. Capital Programme
The proposed financial plan submission for the Dorset system as at 27th March 2025 was a breakeven position, which is an improvement from the February draft plan submission of an £80.9m deficit. The improvement relates to alignment of system plan assumptions, changes to assumed income, and Integrated Care Board (ICB) commissioning intentions which was presented to, and discussed in detail amongst committee members. The Committee agreed to recommend approval of the plan to the DCH and

	DHC Board and supported the proposal to delegate authority to the CEO and CFO to make amendments to the plan if needed. **Policies** A cleanse of the policy system is underway at DHC to ensure the right policies are in the correct portfolios as outlined in committee terms of reference and whether the documents are obsolete. The committee were assured a process is in place to be complete by May 2025 for DHC with implementation for DCH in March 2026. **The following escalation reports from sub groups were received for assurance by the committee members:** • DHC – Capital Investment Meeting – Better Quality, Better Value • DCH – Capital Planning and Space Utilisation Group – – Value Delivery Board – – SubCo Ltd - Escalation report and performance report
Decisions made at the meeting	Approvals by DCH and DHC committees: • 2025/2026 Operational Plan Approved • Proposal to delegate authority to the CEO and CFO to make amendments to the operational plan if needed supported • Approval of Strategy Enabling Plans, following thorough review and discussion at the informal meeting of the committee in February 2025 • Approval of Shared Services Business Case • Approval of One Dorset Procurement Business Case Approvals by the DCH committee: • Approval of Business Case – New Hospital Programme Generators • Approval of Renal Dialysis Unit Refurbishment, noting that the proposal delivers capacity to maintain the service whilst the business case for a longer-term solution is worked up. • Approval of DCH Fortuneswell Pharmacy Development & Sub Co proposal
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance				
	23/09/2024	**25/11/2024**	**27/01/2025**	**24/03/2025**
Quorate?	Y	Y	Y	Y
Dave Underwood	Y	Y	Y	Y

Chris Hearn	Y	Y	Y	Y
Rachel Small	Y	Y	Y	Y
Anita Thomas	Y	Y	Y	Y
Andreas Haimbock-Tichy	N	Y	N	N
Frances West			Y	Y
Lucy Knight			Y	Y
Alastair Hutchison		Y		N
Rachel Wharton			Y	Y
Stephen Tilton	Y	Y	Y	Y
Nick Johnson	Y	Y	Y	Y

Report to	Board of Directors	
Date of Meeting	8th April 2025	
Report Title	Balanced Scorecard- An integrated report for the reporting month of February 2025	
Prepared By	Adam Savin, Director of Operational Planning and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer Claire Abraham, Deputy Chief Finance Officer Emma Hallett, Deputy Chief People Officer Jo Howarth, Director of Nursing (Acute Care)	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Safety and Quality, capacity and demand and strategic risks	
Financial	ERF	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

The Trusts Balanced Scorecard brings together key indicators under four dashboards of Quality and Safety, performance, People and finance.

All indicators are covered in detail in the respective sub-board committees and therefore, this paper does not attempt to duplicate the committees work or the deep dives, but rather provider an oversight of them combined. The pack of Board papers include the sub-board committee escalation reports, which have been written by each Chair and in conjunction with this report, provides the opportunity for triangulation.

Key areas to highlight:
Quality

- Emergency readmissions within 30 days of discharge has increased from 9.47% to 10.01%. This is below the 13% target but is special cause variation of a concerning nature, with a mean of 8.43%.
- Electronic Discharge Summary sent within 24h of discharge remains below target at 73.85% but it has improved by 10% since December, which was at 63.73%. The metric is special cause variation of a concerning nature, with a mean of 77.03%.
- SHMI has remained within the expected range and continues to show as special cause variation of an improving nature, with a value of 1.04 against a mean of 1.13.

Performance

- UEC performance against the 4 hour standard, did meet the national planning guidance of 78% in February and is showing as common cause variation with a year to date value of 78.07%.
- Cancer performance is being impacted by increasing demand, but a return to achievement of 28 day to diagnosis was achieved. However, the 62d treatment standard was missed by 0.5% for February.
- Patients waiting the longest for elective treatment have reduced and the total waiting list size has now met trajectory for four months.
- Diagnostic performance has improved and is showing as special cause variation of an improving nature, but it should be noted the total waiting list size has increased.

People

- Essential skills rate reduced to 87% in month, 3% below target
- Appraisal rate reduced to 77%, remaining below target
- Vacancy rate reduced to 3.1% and remains better than the target
- Turnover remained at 9.3% and remains better than target
- Sickness rate reduced to 4.8%, but remains above the target

Finance

- Adjusted financial plan showing as a confirmed overspend.
- Agency spend reducing and with improved medical and nursing agency spend.
- Capital expenditure is slightly behind plan, due to timings of spend (NHP).

Recommendation
The Board are asked to receive the report for assurance.

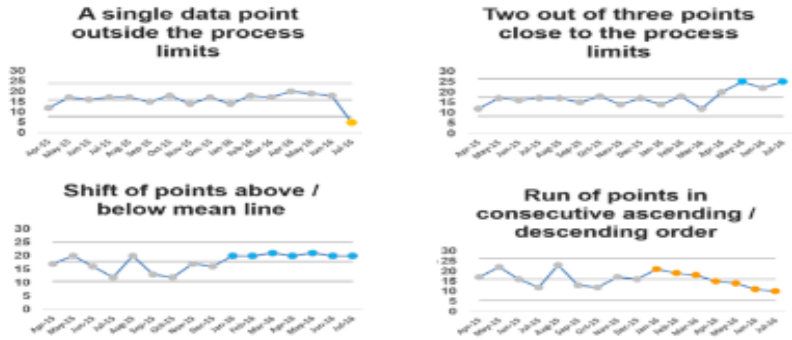
1) Understanding Statical Control Charts (SPC)

Is Performance Changing?

Statistical process control (SPC) charts help us understand if the performance of a metric is changing significantly.

We use rules (examples seen on the right) to identify significant unusual variation, which is highlighted on the charts.

Once significant variation has been identified we can focus attention on areas that need investigation and action.



What are Summary Icons showing?

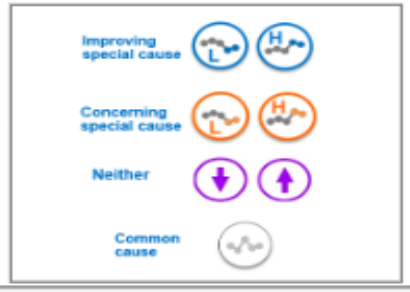
Blue icons indicate significant improvement or low pressure.

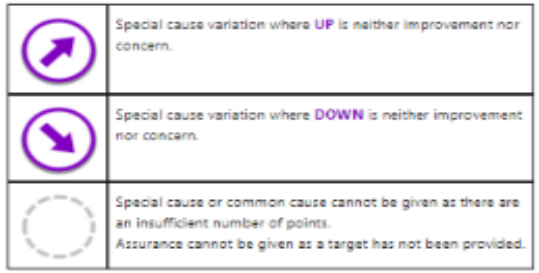
Orange icons indicate significant concern or high pressure.

Purple icons indicate direction of change, for metrics where a judgement of improvement or concern is not appropriate.

Grey icons indicate no significant change ('Hit and Miss').

For further details please refer to 'SPC Icon Descriptions' tab.





What is a Moving Range Chart showing?

Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

The chart can determine the data points wherein the special cause variation may be present.

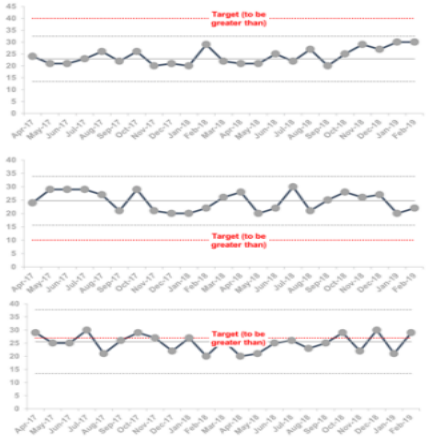
The centre line is the average value of all moving ranges.

The dashed line is the upper process limit and if a point breaches this line, this is where special cause variation may be present.

The moving range chart will display below all SPC visualisations.

Assurance icon

Up is good (need to be greater than the target



Failing process (F)
target way above the process limits so it's a failing process, unlikely to ever meet the target without redesign and we use an orange F for FAIL

Capable process (P)
target way below the process limits so it's a capable process and likely to always meet the target and we use a blue P for PASS

Unreliable process (flip flop) (?)
where the target falls in the middle of the process limits and is likely to flip flop and we use a grey ? This is to show the process may or may not meet target consistently

Variance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
~	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
H	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.

2) Executive Summary

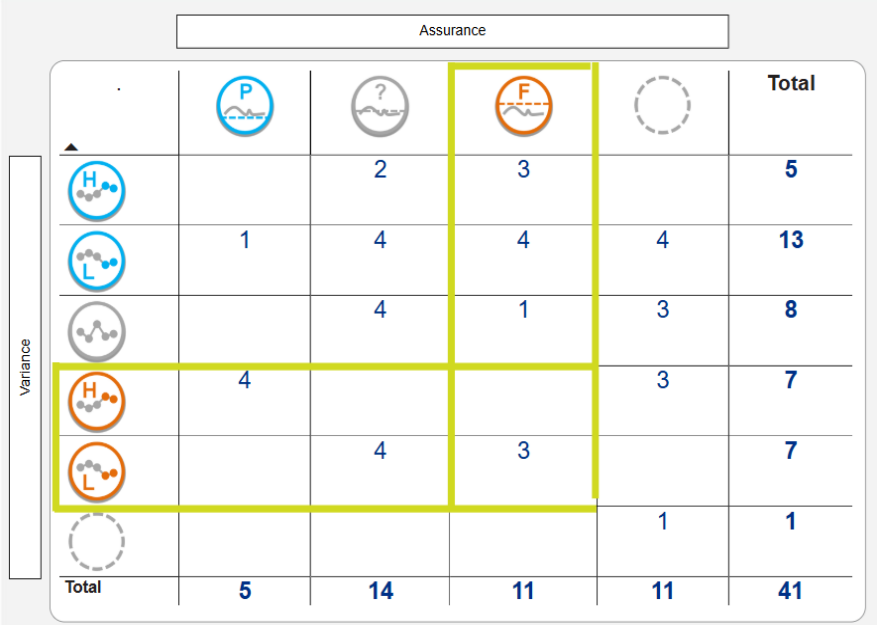
For the reporting month of February 2025, there are 12 indicators that are failing the target and showing as special cause for concern, this compares to 11 in the reporting month of December 2024.

This may mean the process does not easily lend itself to representation as an SPC chart or that without intervention the process will not deliver the required outcome. Each is addressed below and where appropriate other measures described which give a more rounded perspective on the Trust performance within that section.

For the people dashboard, 2 metrics has a variance of special cause variation of a worsening nature, all others are improving or common cause variation. For finance, 2 have a variance of special cause variance of a declining nature, 2 of an improving nature and the rest common cause variation. For performance, 5 metrics are of a worsening nature, 6 improving and 4 common cause variation. For quality and safety, 4 metrics are a declining nature, 6 an improving and 2 common cause variation.

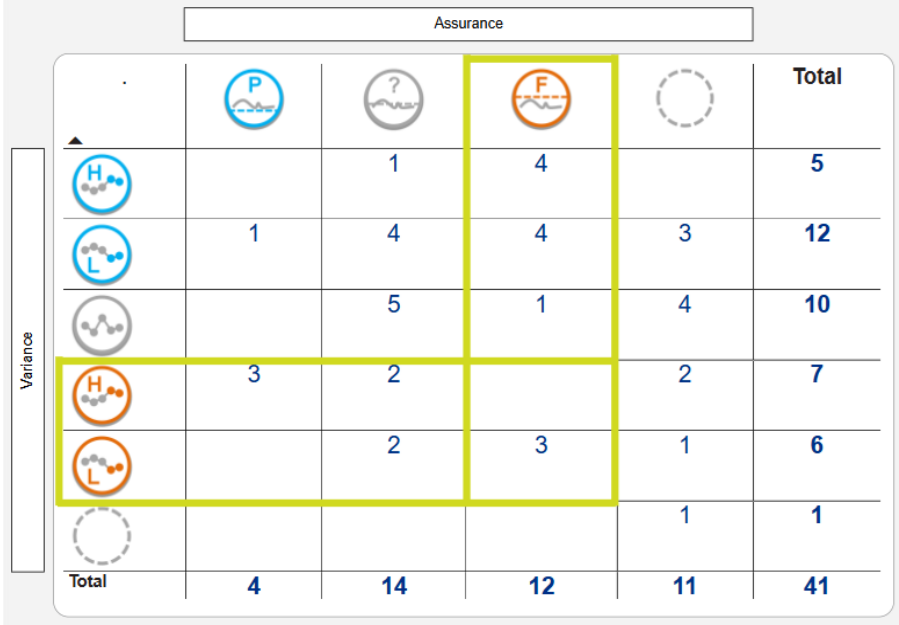
There are 10 indicators, across all dashboards (therefore the balanced scorecard) that have not got a target, therefore assurance cannot be given either way, this is 1 lower than the last reporting round.

December 2024 data



Variance \ Assurance	P	?	F		Total
H		2	3		5
L	1	4	4	4	13
		4	1	3	8
H	4			3	7
L		4	3		7
				1	1
Total	5	14	11	11	41

February 2025 data



Variance \ Assurance	P	?	F		Total
H		1	4		5
L	1	4	4	3	12
		5	1	4	10
H	3	2		2	7
L		2	3	1	6
				1	1
Total	4	14	12	11	41

The matrix summaries the number of metrics (at Trust level) under each variance and assurance category. The Trust is aiming for the top left of the grid (special of improving nature, passing the target). Items for escalation based on indicators which are failing target or unstable (hit and miss) and showing special cause for concern are highlighted in yellow.

3) Quality and Safety dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Effectiveness	Inpatient - EDS % Available < 24 Hours of Discharge	0 - Total	Feb-25	73.85%	90%	-16.15%	77.03%	67.21%	73.85%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Feb-25	86.81%	100%	-13.19%	87.45%	83.02%	86.81%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	Jan-25	10.01%	13%	-2.99%	8.43%	9.7%	10.01%		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Feb-25	96.94%	94%	2.94%	92.14%	86.88%	96.94%		
Safety	Incidents - Confirmed Never Events	0 - Total	Feb-25	0	0	0.00	0.07	0	1		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Incident Date	0 - Total	Feb-25	0			0.11	0	0		
Safety	Incidents - Medication Incidents by Incident Date	0 - Total	Feb-25	73			64.37	97	963		
Safety	Incidents - Pressure Ulcers Category 4 Hospital Acquired by Incident Date	0 - Total	Feb-25	0	0	0.00	0.1	0	2		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan...	0 - Total	Feb-25	0	0	0.00	0.39	0	1		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Feb-25	2	3	-1.00	2.59	3	27		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Feb-25	4	5	-1.00	2.92	4	26		
Safety	Inpatient - SHMI Value	0 - Total	Sep-24	1.04	1	0.04	1.13	1.12	1.04		

- **IPM**
  Cases of Norovirus remain high both nationally and locally, significantly impacting on the community and neighbouring trusts. The trust is now running above trajectory level for Clostridioides Defficile this is also reflecting the national picture and UKSA has stood up a national incident response.

- **Tissue Viability**
  Roll out of PURPOSE T continues with only 2 areas remaining. New hybrid mattresses have been installed in Stroke, Mary Anning & Purbeck. A total of 41 hospital acquired pressure ulcers were reported in February.

- **Complaints**
  The team are seeing some positive results with the new process. Now only 14 complaints remain open under the previous process. Next steps are to work towards full implementation of the closer look investigation process.

- **FFT**
  Timelines reviewed so FFT reporting is now in line with Quality Committee (month in arrears). Jan 98.2% would recommend the service. Work continues to explore ways to increase the completion of FFT in Maternity and ED areas.

- **Mixed sex accommodation**
  There was a decrease in the number of MSA breaches in February, with 17 patients being affected

- **Medication Incidents**
  There continues to be a positive reporting culture in relation to medication incidents, with the majority being low or no harm events.
  To discuss resetting the SPC variation parameters with the BI team.
  Omitted doses and insulin related incidents all remain within expected parameters and have reduced since the previous month

- **ED**
  EDS % <24hrs performance has improved since December
  EDS % < 7 days remains consistent at a current average of 85%.
  Quality Governance team are leading on a QI project with 5 Resident Drs to review the EDS process
  Re-admissions within 1 month remain below the upper parameter and remain around 10%.

- **Standardised Hospital Mortality Rate (SHMI)**
  Standardised Hospital Mortality Rate continues to improve and is demonstrating a positive special cause variation as it tracks closer to 1.00. Awaiting the updated data as 5 months in arrears.

**Narrative provided by Louisa Way, Deputy Director of Nursing (Acute Care).*

4) Performance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Cancer	Cancer - 28 Day Faster Diagnosis Standard Performance	0 - Total	Feb-25	76.35%	77%	-0.65%	71.57%	76.15%	76.35%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Feb-25	89.71%	96%	-6.29%	95.81%	91.63%	89.71%		
Cancer	Cancer - Patients Waiting 62+ Days from Referral to Treatment	0 - Total	Feb-25	65			78.83	86	803		
Elective	Theatres - Capped Utilisation	0 - Total	Feb-25	77.07%	85%	-7.93%	69.28%	73.3%	77.07%		
Elective	Theatres - Uncapped Utilisation	0 - Total	Feb-25	82.71%	85%	-2.29%	74.34%	77.81%	82.71%		
Outpatient	Diagnostic - Percentage Patients Waiting <6 Weeks Test	0 - Total	Feb-25	86.18%	95%	-8.82%	76.66%	87.58%	86.18%		
Outpatient	RTT - 65+ Week Waits	0 - Total	Feb-25	9			580.39	383	9		
Outpatient	RTT - 78+ Week Waits	0 - Total	Feb-25	0			255.89	55	0		
Outpatient	RTT - Waiting List Size	0 - Total	Feb-25	20761			19841.52	21023	20761		
UEC	ED - Ambulance Handovers Average (Minutes)	0 - Total	Feb-25	19.48	30	-10.52	14.53	18.78	19.48		
UEC	ED - DCH 4 Hour Performance %	0 - Total	Feb-25	57.75%	70%	-12.25%	68.72%	65.4%	57.75%		
UEC	ED - ED Attendances % Waiting 12+ Hours	0 - Total	Feb-25	10.84%	7.77%	3.07%	4.59%	8.77%	10.84%		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Feb-25	78.07%	78%	0.07%	81.65%	80.64%	78.07%		
UEC	Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occup...	0 - Total	Feb-25	21.29%			20.98%	23.55%	21.29%		
UEC	Inpatient - Average Number of No Criteria to Reside Patients	0 - Total	Feb-25	66	38	28.00	75.48	73	66		

For the reporting month of February 2025, 6 out of 15 metrics were special cause variation of an improving nature, 4 were common cause variation and 5 of a declining nature.

The 31-day cancer indicator did not achieve the target. The assurance is hit or miss for the 31-day standard, which occurs when the target lies between the process limits. For February, the trust did not achieve the 62-day treatment standard but did achieve the 28 day to diagnosis standard (77% target is by March 2025).

The two theatre utilisation indicators have improved, both capped and uncapped theatre utilisation is special cause of an improving nature, but with an assurance rating of fail, with the process not capable and will continue to fail the target without process redesign.

Baker,Abi
02/04/2025 16:28:00

The percentage of patients waiting 6 weeks or less for a diagnostic procedure has improved and with consistent improvements for the last few months, it is showing as special cause of an improving nature but with assurance of fail.

In terms of the elective waiting list, the number of patients waiting over 65 and 78 weeks is special cause variation of an improving nature as the cohort of patients that have been waiting the longest, continues to reduce. The size of the waiting has now hit trajectory since November, as activity levels are now higher than the growth in referrals. The waiting list at the end of 2024/25 will be lower than at the start of the year.

Average ambulance handover times have improved since the last Board reporting, the indicator is special cause of a concerning nature however, and with an assurance of pass, the process is capable of consistently passing the target. Performance of the ED 4-hour standard all (including MIUs) is special cause variation of an improving nature, with no significant changes and the process will continuously hit or miss the target. Performance improved in February and returned to achieving the national planning guidance target of 78%.

Full details of this and all metrics within the performance dashboard, are covered in the Finance and Performance Committee.

**Narrative provided by Adam Savin, Director of Operational Planning and Performance.*

5) People dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Growing for our Future	Essential Skill Rate	0 - Total	Feb-25	87%	90%	-3.00%	88.79%	89%	87%		
Looking After our People	Appraisal rate	0 - Total	Feb-25	76.7%	90%	-13.30%	75.74%	78.3…	76.7%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	Jan-25	4.77%	3.75%	1.02%	4.06%	4.29%	4.77%		
Looking After our People	Staff Turnover Rate	0 - Total	Feb-25	9.38%	12%	-2.62%	9.69%	10.0…	9.38%		
Looking After our People	Vacancy Rate	0 - Total	Feb-25	3.11%	5%	-1.89%	6.47%	4.52%	3.11%		

- Essential skills rate reduced to 87% in month, 3% below target
- Appraisal rate reduced to 77%, remaining below target
- Vacancy rate reduced to 3.1% and remains better than the target
- Turnover remained at 9.3% and remains better than target
- Sickness rate reduced to 4.8%, but remains above the target

Essential skills reduced to 87%, 3% short of achieving the target. At present this is common cause variation with no significant change, although due to the fluctuating nature of this indicator, the assurance classification remains as fail, without process redesign. Recovery plans are underway in the five training elements where individual compliance is under 80%. The overall appraisal rate in Month 11 was 77%, this remains common cause variation with no significant change. The assurance classification remains as fail, without process redesign. 80.5% of staff survey respondents stated that they had had an appraisal in the past 12 months, indicating that a small proportion of appraisals are not being recorded once completed. This is being investigated further. Feedback relating to the quality of appraisals remains good, both in the appraisee follow up survey and the relevant staff survey questions. Both the turnover and vacancy rates remain largely unchanged in month, these indicators remain special cause of an improving nature, with processes capable of consistently passing the targets. The overall sickness percentage decreased in month 10 (January) to 4.8% but remains above target, indicating special cause of a concerning nature, although the trend matches the usual seasonal pattern of absences. The rolling year sickness figure is 4.3%.

**Narrative provided by Emma Hallett, Deputy Chief People Officer*

6) Finance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure	0 - Total	Feb-25	2468	2473	-5.00	1946.34	1555	18589		
Capital	Cash Position	0 - Total	Feb-25	11776	8466	3,310.00	8537.91		11776		
Revenue	Adjusted Financial Position	0 - Total	Feb-25	1001	1613	-612.00	-287.04	855	-9374		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Feb-25	18.68%			22.35%	26.81%	18.68%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Feb-25	4.12%			6.74%	7.2%	4.12%		
Value Board	Agency Spend	0 - Total	Feb-25	328.8	833	-504.20	956.74	803	6042.03		
Value Board	Efficiency Delivery	0 - Total	Feb-25	807	1740	-933.00	372.8	450	7170		
Value Board	Off Framework Agency Spend	0 - Total	Feb-25	7	83	-76.00	82	128	276		

- **Adjusted Financial Position (against control total)**
  In line with reported RAFOT trajectory at M11. Overspend against planned deficit position linked to increased Insourcing due to 65 ww and activity above originally planned levels, unachieved CIP, costs supporting Industrial Action, inflationary RPI costs above planned levels, pay award shortfall, 33% increase for drugs specifically Gastro, Derm and blood thinner drugs being patient specific, catering incl provisions, laundry and utilities/rates, redundancies incurred, offset by agency improvement against plan although slowing pace and medical cover for sickness. In line with RAFOT trajectory delivery for M11.

- **Agency Spend**
  Nursing agency improvement with medical locum usage Ophthalmology, Anaesthetics, Obs & gynae curbed in December however expected to resume in January. Nursing challenging patient specialising and cover for SCBU, ED and Stroke. Medical agency usage escalated to SRO CMO for enhanced oversight and action plans.

- **Off Framework Agency Spend**
  Decreases in usage of Off Framework noting areas of essential usage reviewed and limited to Emergency Department, Critical Care, Kingfisher paediatric ward and Special Care Baby Unit (SCBU), aligned to national off framework removal expected from July 2024 - break glass protocol only in use.

- **Efficiency Delivery**
  KEY ACTION AREA. Significant delivery in month with focus on low & medium risk schemes for delivery, especially security and income generation schemes having been delayed (Dir of E&F action plan focus) offset by Covid related cost savings in month and cost reduction linked to agency improved spend against plan. Deep dive report presented to October F&PC and weekly update report to Recovery Group.

- **Cash**
  23/24 ERF payment received along with pay award funding paid out and HEE income for January. National revenue support received in April totalling £1.5m with further request submitted for February noting December and January requests were declined, Board approved pending national outcome. Continued risk of cash shortfall expected Q4 and beyond pending 25/26 allocations.

- **Capital expenditure (total)**
  Behind plan YTD due to NHP enabling works timing, offset by internally funded schemes ahead of plan (Ridgeway, East Wing and medical equipment purchases timing).

*Narrative provided by Claire Abraham, Deputy Chief Financial Officer.

7) All metric glossary

MetricName	MetricDescription
Cancer - 28 Day Faster Diagnosis Standard Performance	Percentage of patients meeting the 28 day faster diagnosis cancer standard (from referral to point where given an all clear or confirmed diagnosis). Sourced from Somerset Cancer Register (SCR).
Cancer - 31 Day Decision to Treatment Standard Performance	Percentage of patients meeting the 31 day decision to treatment cancer standard (based Treatment for DCH treated patients). Sourced from Somerset Cancer Register (SCR).
Cancer - Patients Waiting 62+ Days from Referral to Treatment	Number of patients waiting longer than 62 days from cancer referral to treatment following a screening service referral. Sourced from the DCH Manual Data Collection Portal via the Cancer Team.
Complaints - Formal Complaints Received	Number of formal and complex complaints raised based on received date. Sourced from Datix.
Diagnostic - Patients % Waiting < 6 Weeks for Diagnostic Test	Percentage of Patients waiting less than 6 weeks for a diagnostic test in line with DM01 methodology. Sourced from DM01 Monthly Position.
ED - Ambulance Handovers Average (Minutes)	Average DCH ambulance handovers in Minutes against 30 Minute Average Target. Sourced from ED SWAST information.
ED - DCH 4 Hour Performance %	Percentage of patients with an unplanned DCH Emergency Department visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS.
ED - ED Attendances % Waiting 12+ Hours	Percentage of patients with an unplanned DCH Emergency Department visit lasting longer than 12 hours. Excludes patients marked as streamed. Sourced from ED Agyle/PAS information.
ED - Overall 4 Hour Performance %	Percentage of patients with an unplanned Emergency Department/MIU visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS and MIU information.
Finance - Adjusted Financial Position	Finance Spend (£000) Adjusted financial performance surplus or deficit. Sourced from Finance team.
Finance - Agency Spend	Agency Spend (£000). Sourced from Finance team.
Finance - Capital Expenditure	Capital Expenditure (£000). Sourced from Finance team.
Finance - Cost Position	Cash position of the Trust (£000) noting this is a key risk area for 2024/25. Sourced from the Finance Team.
Finance - Efficiency Delivery	Paid CIP (£000) for efficiency delivery. Sourced from Finance team.
Finance - Local Supplier % of Catering Spend	Percentage of catering spend with local suppliers. Sourced from the Procurement team.
Finance - Local Supplier % of Total Spend	Percentage of total spend with local suppliers. Sourced from the Procurement team.
Finance - Off Framework Agency Spend	Off Framework Agency Spend (£000). Sourced from Finance team.
Friends and Family - Overall % Recommendation Rate	Percentage of overall Friends and Family recommendation. Sourced from the Patient and Public Experience team.
Incidents - Confirmed Never Events	Number of occurances of confirmed Never Events based on updated date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Falls Resulting in Severe Harm or Death by Reported Date	Number of occurances of falls catagorised as severe or death severity of harm caused, based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Medication Incidents by Reported Date	Number of occurances of medicine incidents based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital Acquired (Category 3) by Reported Date	Number of occurances of hospital acquired (confirmed) category 3 pressure ulcers by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Serious Incidents Investigated and Confirmed Avoidable by Panel Date	Number of occurances of serious incidents investigated and confirmed avoidable by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	Number of occurances of hospital onset healthcare associated Clostridium difficile (C. diff) incidents by specimen date. Sourced from HCAI data.
Infection Control - Gram Negative Blood Stream Hospital Onset Infections	Number of occurances of hospital onset gram negative blood stream infection incidents by specimen date. Sourced from HCAI data.
Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occupancy	Percentage of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS /
Inpatient - Average Number of No Criteria to Reside Patients	Number of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS /
Inpatient - EDS % Available < 24 Hours of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 24 hours of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - EDS % Available < 7 Days of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 7 days of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - Emergency Re-Admissions % (1 month in arrears)	Percentage of emergency re-admissions to hospital within 30 days of previous admission. Excludes patients under the age of 16 on original admission. Sourced from Emergency Readmission
Inpatient - SHMI Value (5 months in arrears)	Ratio result of Summary Hospital-level Mortality Indicator (SHMI) which reports applicable deaths within hospital, or within 30 days post discharge against expected (does not include Covid related deaths). Results show the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of
RTT - 65+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 65 weeks or longer. Sourced from PAS.
RTT - 78+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 78 weeks or longer. Sourced from PAS.
RTT - Waiting List Size	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment. Sourced from PAS.
Theatres - Capped Utilisation	Percentage of planned theatre sessions that were utilised, based on Capped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Theatres - Uncapped Utilisation	Percentage of planned theatre sessions that were utilised, based on Uncapped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Workforce - Appraisal rate	Percentage of applicable appraisals completed within time frame expected. Sourced from Workforce team.
Workforce - Essential Skill Rate	Percentage of applicable essential skills completed within time frame expected. Sourced from Workforce team.
Workforce - Sickness Rate (1 month in arrears)	Sickness Rate. Full Time Equivalent (FTE) sick / FTE Days Available. Source ESR.
Workforce - Staff Turnover Rate	Percentage showing staff turnover rate based on a 12 month rolling view. Sourced from Workforce team, original source ESR.
Workforce - Vacancy Rate	Percentage showing Trust vacancy rate (budgeted FTE minus staff in post). Excludes positions with a frozen or proposed Hiring Status, positions with Org Level 2 of Honorary, Widows & Widowers, Dump Posts, Volunteers or Nurse Bank, positions with a Cost Centre of Nursing Relief Pool RN or HCA, and positions noted as Registered Nursing Degree Apprentices. Sourced from ESR.

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors	
Date of Meeting	8th April 2025	
Report Title	DCH Finance Report – Month 11 2024/25	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Identify risks and mitigations associated with plan delivery, financial sustainability	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	System financial plan delivery	

Executive Summary

Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a break even plan to NHS England (NHSE) on 10th June 2024 for the financial year 2024/25.

Key Messages

Month eleven delivered a surplus of £1 million after technical adjustments, being £0.6 million away from plan of £1.6 million surplus. The year to date position is £8 million away from the reported plan standing at an actual deficit of £9.4 million. This position is in line with the Trusts risk adjusted forecast outturn trajectory plan of a £9.4 million planned deficit position at month eleven.

Insourcing above original planned phased levels; ongoing challenges with drugs and shortfall in efficiency delivery against planned levels drive the position in month.

The risk adjusted forecast outturn by year end remains intact noting the highlighted risks and focus on identified mitigating actions. Active dialogue is underway with system partners and the national team with regards to the outcome of the overall risk adjusted forecast outturn (RAFOT) delivery position, with a verbal update to be provided to the Committee noting this fast paced changing landscape.

Factors driving the year to date overspend remain as previously reported: costs supporting Industrial Action; other high drugs costs specifically for Gastroenterology, Dermatology, Rheumatology, Pediatrics and blood products which are largely patient specific. Costs supporting operational pressures including levels of patients with no criteria to reside, and inflationary RPI costs above planned levels are being incurred for provisions, catering, laundry and utilities.

The Trust continues to see increased patient acuity throughout the month with escalated beds used in the region of 4, and circa 55 no criteria to reside (NCTR) patients being supported which were captured at the end of February (not average).

Agency expenditure has continued at lower than budgeted levels, with total month spend of £0.3 million and year to date spend at £6.1m. This time last financial year agency expenditure totaled £12.6m demonstrating a significant improvement in this area.
Current year expenditure is split across Nursing areas and medical agency cover for sickness and vacancies in Ophthalmology, Anesthetics and Obs & Gynae specialties.
Break glass Off Framework expenditure is being incurred each month, with £0.07 million incurred in month eleven resulting in £0.3 million year to date, with NHS England expecting nil Off Framework spend from July 2024.

An estimated income position for elective recovery funding (ERF) following the national baseline target revision to 109% for Dorset has been included in the position in line with NHSE methodology.

The Trust wide efficiency target for the year stands at £14.4 million and is circa 5% of expenditure budgets in line with peers and national planning expectations.
The target has been identified in full with year to date delivery at 50% of the target being £7.2 million, however efficiency delivery remains a significant challenge for the Trust. Progress against planned delivery has significantly picked up pace since month eight with a renewed focus required in order to deliver the identified schemes in the latter parts of the financial year. The Trust is on track to deliver £8.3m of efficiencies this financial year which is the most in Trust history.

Capital expenditure for month eleven is broadly in line with in month £2.5m plan however year to date ear to date spend is £18.6 million and behind plan by £5.3 million largely due to NHP enabling works offset by internal schemes being ahead of plan by £0.9 million, both due to timing.

The cash position to February amounts to £11.8 million, being ahead of expected forecast due to timing of supplier payments made and income received relating to ERF.

Cash remains a high risk area for the Trust with modelling indicating cash support will likely be required for the next financial year pending confirmation of the 2025/26 funding allocation confirmations.

Key Actions

- The Trust is actively deploying targeted recovery actions to ensure mitigations and corrective steps are in place for all overspending areas in order to support delivery of the break even position by year end, noting significant challenges associated and risk to delivery of this as outlined in the report. A bi-weekly Executive led DCH Recovery Group is driving mitigating actions to tackle the risks to the position.

- Target areas include Non clinical bank pay; Facilities incl non pay & provisions; external security; medical additional sessions and medical agency usage; theatre utilisation, NCTR and escalation beds.

- Efficiency support meetings led by CFO ongoing with all areas, overseen by Value Delivery Board

- Working group in place to recover WTE to March 2023 levels overseen by Executive led SRO and DCH Recovery Group meeting, noting a staged approach to recover to March 2024 levels in the first instance (3470 WTE)

- Ongoing daily cash monitoring – cash shortfall risk with ongoing efficiency delivery essential in line with planned levels and grip and control paramount

- Agency monitoring continues with medical focus escalated to CMO
- Capital programme monitoring noting over subscription and current internal programme overspend.

Recommendation

The Board is recommended to:

1) NOTE the month eleven financial position for the financial year 2024/25 and associated risk to delivering the break even position with key recovery actions taking place.

NHS
Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2024/25

February 2025 - Month 11

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

Financial Position Update - February 2025

Executive Summary

Dorset County Hospital NHS Foundation Trust

A summary of progress is presented for the period of February 2025 and is compared with the re-phased plan submitted on 10th June 2024 to NHS England (NHSE).

In February 2025, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a month 11 surplus of £1 million after technical adjustments, an adverse performance of £0.6 million against the revised plan of £1.6 million surplus.

This overspend in month has been driven by; increased insourced activity including 65 ww investment and inflationary RPI costs above planned levels for provisions, catering, laundry, utilities and drugs, specifically Gastroenterology, Dermatology and blood products. The Trust has also seen heightened operational pressures and increased patient acuity throughout the month, including continued specific pressure around Mental Health patients and increased use of off framework agency. Escalated beds at the end of the month were 4 with circa 55 no criteria to reside (NCTR) patients being supported. Agency expenditure has maintained a reduction against 2023/24 totals due to the impact of the agency rate reduction and increase in substantive recruitment, however ongoing medical rota gaps across ED, General Medicine and Urology are being covered at higher rates than budgeted.

The Trust wide efficiency target for the year stands at £14.4 million and is circa 5% of expenditure budgets in line with peers and national planning expectations. The programme is fully identified however contains 47% of high risk schemes. Delivery to date stands at £7.2 million. This is c£5 million behind phased plan of delivery to month 11. In addition to this delivery, contributing cost avoidance and cost reduction is now being detailed (£3.3 million YTD). Efficiency delivery remains a significant high risk for the Trust with laser focus required from all responsible officers to deliver schemes as planned.

Pay is over plan mainly due to the 2024/25 pay award including backdated payments for months 1-9, impact of this pay award has not been included in the plan figures. Others areas above plan include increase in successful registration of training nurses and the national/system agreed increase of Band 2 to Band 3 Agenda for change movement. Agency usage to cover vacancies and to support operational pressures has continued, albeit at a lower rate than previous months. Non pay is over plan due to high consumable costs including drugs and activity volumes linked to recovery of elective services in conjunction with heightened inflationary pressures.

The Trust is progressing with the capital programme for 2024/25, month 11 YTD spend totalling £18.9 million, a net £5.3 million behind rephased plan due to underspends on externally funded projects. Externally funded projects are £5.5 million behind plan due to the changes in the spend profile of the New Hospital Programme (NHP) enabling works. Purchases of IFRS16 Leases are a further £0.7 million behind plan but the internally funded and donated projects are ahead of plan by £0.9 million relating to early spend on East Wing Theatre and 2023/24 rollover spend on Ridgeway. There is significant pressure on the internally funded programme this year due to works on the two significant Estates schemes (Chemo and East Wing Theatre) and high demand for backlog works and medical device replacement.

The cash position as at 28 February was £11.8million, £3.3 million ahead of plan. The Trust requested and was granted £1.5m of national revenue support received in April. The Trust requested a further £3.0m of cash support in March as modelling indicated a cash shortfall by the end of the year. However, this request was rejected by NHSE as a result of additional funding streams made available to the Trust. These include an additional £2 million for system support from NHSE and £5.7 million from Dorset ICB relating to 2024/25 ERF to M12.

Financial Position Update - February 2025

Key Risks

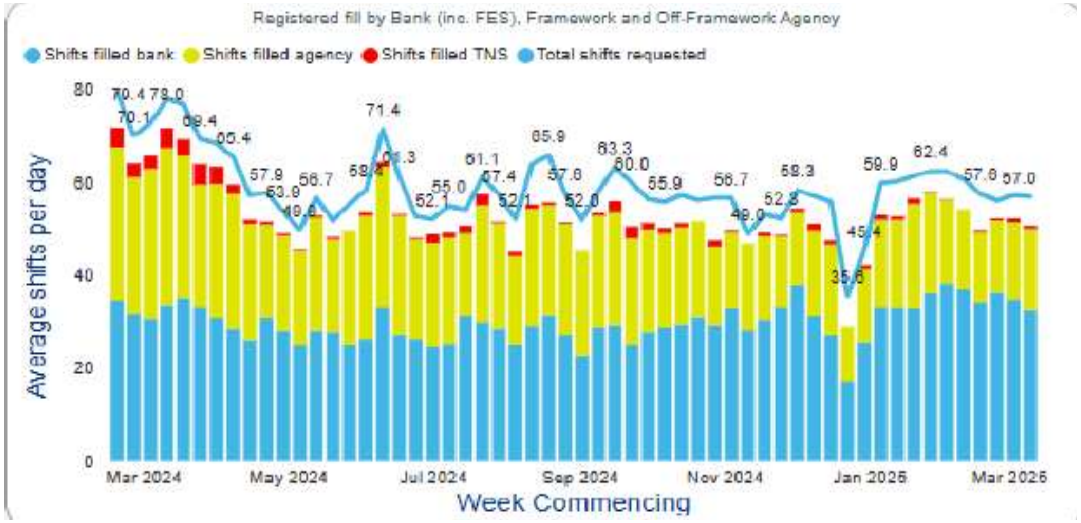
Dorset County Hospital NHS Foundation Trust

Red Risks:

The Trust has an efficiency delivery requirement of £14.4 million in order to reach the planned full year break even position. The target is now fully identified, however £6.8 million of the this is made up of High Risks schemes (47%) including workforce review and productivity stretch. Without continued development of these schemes, the Trust's deficit position will worsen. Efficiencies delivered non recurrently where recurrent is expected will also negatively impact the Trusts underlying deficit position.

The Trusts approach to efficiency delivery is led by the Value Delivery Board. This is designed to reinforce the accountability and deliverables of programmes across the Trust.

Agency expenditure has improved since last year due to a combination of factors including system agency rate reduction and vacancy level decreases. NHSE mandated all off framework agency spends to cease completely from July 2024. The Trust has managed to largely achieve this, with the exception of Mental Health escalation requirements. This has resulted in the Trust exceeding it's FYE reduction of £1 million on spend, which currently stands at £2.1 million. The opening of Portisham Ward to support the extreme pressures seen in ED has also seen an impact on the usage of agency since month 5. Active plans in place as part of the internal High Cost Agency Reduction group, which is primarily focusing on nursing, are continuing to help prevent further deterioration of the position against plan and begin to work further on medical agency and locum spend. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust is beginning to increase bank usage whilst decrease agency usage (maintaining patient and staff safety and quality levels). Agency notice has now reduced to 48 hours in order for Bank Staff to access the shifts in the first instance. So far, this has not impacted fill rates.



Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Financial Position Update - February 2025

Key Risks

Dorset County Hospital
NHS Foundation Trust

Red Risks:

Financial Forecast Risk

There is a risk of delivering the break even position. Drivers include supporting industrial action, patient specific high drugs costs, escalated bed base and operational pressures, agency usage, efficiency under delivery and inflationary costs above planned levels. The Trust is actively deploying targeted support towards recovery and mitigations, led by the CFO and supported by the wider Executive team in order to mitigate the risk to financial balance with stretch targets agreed for efficiencies, productivity and agency to the end of the financial year.

System Elective Services Recovery - income performance

The government has made Elective Services Recovery Funding (ESRF) available to each Integrated Care Board (ICBs) to eventually achieve around 30% more elective activity than was achieved before the COVID-19 pandemic. The financial year 2024/25 national target aims to reach 109% of the activity levels seen in 2019/20 (pre-pandemic).

Dorset County Hospitals target is set at 104% of 2019/20 Elective Activity and as a Dorset system has an ambition to reach 109% of its 2019/20 activity, this will be to alleviate some of the financial pressures within the system and reducing the size of the Dorset waiting list.

Current forecasts indicate the Trust is expected to exceed 109% of the activity levels seen in 2019/20.

Cash Position

There is a risk to cash levels throughout the year due to deficits in the first 9 months of the year and challenging efficiency targets. This risk has been highlighted to NHSE with a request for additional Provider Revenue Support successful for April 2024, with £1.5 million drawn down in the form of Public Dividend Capital. A December, January, February and March request for cash were rejected on the basis of unachievement against YTD financial plan, CIP delivery and Workforce reduction. Following ongoing discussions within the system to assist with cash pressures, the Trust has since received the following income streams earlier than anticipated; £5.7m for 2024/25 ERF and £2m system support. While further discussions are ongoing to identify a longer term cash solution with System and Regional colleagues the short term risk has been mitigated.

Internally Funded Capital

The Trust is set a capital envelope each year which details the maximum internally funded capital spend allowed by the Trust (£7.4 million). Due to significant demands on the capital programme this year there is a risk of exceeding this envelope. The 2024/25 Estates schemes include two large projects (Chemo and East Wing Theatre) plus roll over spend from 2023/24 on Ridgeway and there are significant digital projects also ongoing in year. Consequently there is limited capital budget available for backlog and medical device replacements which are now becoming urgent and unavoidable, resulting in over subscription against the internally funded capital programme. The Capital Planning and Space Utilisation Group (CPSUG) has collated a prioritised and risk scored list from each area to actively oversee, identify and manage this risk. In addition there are ongoing conversations with both the Dorset System and the Regional team to get agreement for a forecast £891k oversubscription against Capital to be offset by the slippages on the capital lease expenditure to a matching value.

Dorset County Hospital
NHS Foundation Trust

Key Risks

Amber Risk:

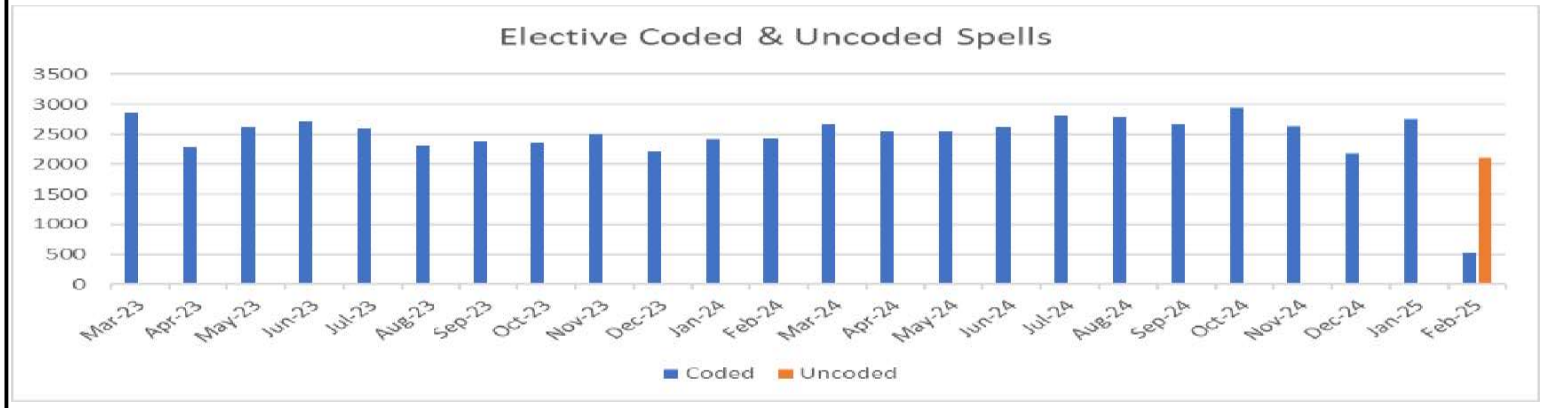
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable element. The variable element of the contract will cover most elective activity: Elective Inpatients, Day cases, Outpatient First Attendances, Outpatient Procedures, Chemotherapy delivery and Diagnostics.

An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National Tariff. Any underperformance against baseline will be repaid at 100% of the national tariff and any over performance will be received at 100% of the national tariff.

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any elective activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at February 2025 the Trust has 4,905 uncoded spells 2,112 are for Elective activity and 2,793 are for Emergency. As demonstrated in the graph below, there is a 2 month lag at the end of each period where coding is completed to meet the applicable freeze dates. Based on coding trends captured over a two year rolling period, no significant coding issues have been incurred.



2024/25 Flex Freeze Dates

Month	Flex	Freeze
Apr-24	20 May 24	19 Jun 24
May-24	19 Jun 24	17 Jul 24
Jun-24	17 Jul 24	19 Aug 24
Jul-24	19 Aug 24	18 Sep 24
Aug-24	18 Sep 24	17 Oct 24
Sep-24	17 Oct 24	19 Nov 24
Oct-24	19 Nov 24	17 Dec 24
Nov-24	17 Dec 24	20 Jan 25
Dec-24	20 Jan 25	19 Feb 25
Jan-25	19 Feb 25	19 Mar 25
Feb-25	19 Mar 25	17 Apr 25
Mar-25	17 Apr 25	20 May 25

Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

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Financial Position Update - February 2025

Recovery Plans

Dorset County Hospital
NHS Foundation Trust

Weekly Executive Recovery Group meeting established with Targeted Service Areas and Recovery Plans
- Weekly Senior Leadership recovery meetings are taking place with specific focus areas
- Recovery plans for overspending areas are identified, with focus on strong cost controls and identification and removal of avoidable costs. Possible mitigations to be considered with additional governance support to evidence efficient working processes
- Regular messaging about Financial position and required efficiency focus is being provided at Divisional Managers weekly meeting, Value Delivery Board and Senior Leadership Group
- Analysis of non-clinical bank pay is taking place with plans to reduce spend in this area
- Other key focus area's include; facilities including non pay & provisions, external security, medical additional sessions, medical agency usage, along with theatre utilisation, NCTR and escalation beds

Income recovery
- Maximise private patient income and ERF income within insourcing budget
- Review activity coding for completeness

Workforce measures
- Strong recruitment controls in place, formal Exec approval needed from weekly Recruitment Control Panel
- Working group in place to recover WTE to March 2023 levels overseen by Exec led SRO - a staged approach has been adopted with recovery back to March 2024 levels (3470 WTE) by year end
- Agency monitoring continues with medical focus escalated to CMO

Investment Reviews
- Review prior investments to gain understanding and assurance that expected benefits will be delivered, reconsider continuation if necessary
- Review investments in progress, ensure in-year benefits or recognised high risk drivers. Current investments paused, while financial implications for 2024/25 are considered

CIP and efficiencies
- CFO CIP support meetings ongoing with all areas, overseen by Value Delivery Board
- Meetings with all areas in train with focus on identified into delivery, all low and medium schemes to be delivered
- Active system recovery meetings in train with unpalatables under review
- Update to progress of Medium and Low risk schemes is reported back to the Recovery Group every week

Cash
- Ongoing daily cash monitoring and weekly cashflow review
- Timely invoicing and early and effective debt collection
- Revenue Support received from both Dorset ICB and NHSE.
- Ongoing discussion with Dorset ICB to ensure all cash payments are received without delay.
- System conversations to request support are also still active on this subject.

Financial Position Update - February 2025
Income & Expenditure

NHS
Dorset County Hospital
NHS Foundation Trust

Income and Expenditure

The overall revenue position is a £1 million in month actual surplus, £0.6 million adverse to plan after technical adjustments. The YTD position is £8 million away from plan. Increased insourced activity, along with continued inflationary pressures drive this. CIP achievement in month was c£1million behind plan, however c£5m behind plan YTD.

The overachievement in Operating Income from patient care activities in month variance is due to; out of contract income including non-recurrent System adjustment to Baseline income £3.3m, estimated month 1 - 11 Elective Services Recovery Fund (ESRF) income and high cost drugs income offset with expenditure.

Pay costs are over plan due to pay award including backdated payments, supporting industrial action in quarter 1, ongoing bank and agency usage covering vacancies, sickness and supporting operational pressures, noting increased patient acuity and a number of patients requiring mental health support. February has seen a continued improved trend in agency costs against 2023/24 levels and the lowest month it has been YTD. The large pay variance is offset largely by income received for externally funded posts - an exercise is currently underway to transfer budget to the appropriate pay lines.

Non pay is over plan due to ongoing above plan drugs costs, inflationary pressures, in particular energy, catering supplies, maintenance contracts, laundry and blood products. Drugs specifically in Gastro have started to use off patent drugs and we are beginning to see use come down at this later part of the year - addressing this area of continued overspend.

Recovery plans are underway with all overspending areas to ensure mitigations are applied to support recovery of the adverse position.

STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance
Operating income from patient care activities	22,026	24,054	2,028	241,309	263,860	22,551
Private Patients	87	153	66	953	1,012	59
Other clinical revenue	37	68	31	407	256	(151)
Other non-clinical revenue	2,825	3,693	867	23,462	27,043	3,581
Operating Income	**24,975**	**27,968**	**2,993**	**266,131**	**292,170**	**26,039**
Total Income	**24,975**	**27,968**	**2,993**	**266,131**	**292,170**	**26,039**
Raw materials and consumables used	(3,221)	(4,615)	(1,394)	(39,425)	(51,061)	(11,635)
Employee benefit expenses:						
Substantive	(14,048)	(15,672)	(1,624)	(154,215)	(172,331)	(18,083)
Bank	(629)	(1,100)	(472)	(8,954)	(11,769)	(2,815)
Agency	(804)	(329)	475	(9,225)	(6,065)	3,127
Other operating expenses (excl. depreciation)	(3,251)	(3,799)	(548)	(39,417)	(44,545)	(5,127)
Operating Expenses	**(21,952)**	**(25,515)**	**(3,562)**	**(251,236)**	**(285,770)**	**(34,534)**
Profit/(loss) from Operations (EBITDA)	**3,023**	**2,453**	**(570)**	**14,895**	**6,400**	**(8,494)**
Other Non-Operating income (asset disposals)	(3)	0	3	(11)	20	31
Total Depreciation and Amortisation	(1,035)	(1,036)	(0)	(11,387)	(11,386)	1
PDC Dividend expense	(408)	(408)	0	(4,490)	(4,490)	0
Total finance income	100	66	(34)	371	769	398
Total interest expense	(64)	(62)	3	(709)	(688)	20
Total other finance costs	(0)	(0)	(0)	(£0)	(£3)	(3)
SURPLUS/ (DEFICIT)	1,613	1,014	(599)	(1,332)	(9,378)	(8,046)
Technical Items Adjusted for:						
Donations Non-Cash Assets	(40)	(48)	(8)	(440)	(396)	44
Depreciation Donated Assets	40	36	(4)	440	393	(47)
SURPLUS/ (DEFICIT)	1,613	1,001	(612)	(1,332)	(9,381)	(8,049)

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Financial Position Update - February 2025
Risk Adjusted Forecast Outturn

NHS Dorset County Hospital NHS Foundation Trust

RAFOT Narrative
Whilst there always remains a risk to the delivery of the break even plan for financial year 2024/25, the Trust is on track at month eleven in line with the RAFOT revised trajectory performance. A number of detailed mitigations have been identified and are being closely monitored through the Trusts bi-weekly Executive led DCH Recovery Group to ensure delivery. This is an active area of focus both locally and nationally, with updates taking place at a substantial pace, as such any updates will be provided verbally to the Committee.

	Position to Month 11			Year End Position Risk @ M11		
Organisation	M11 YTD plan	M11 position	YTD Variance to plan	Year end plan (and reported FOT)	Year end risk adjusted (mitigated) forecast	Variance to Plan (RAFOT position)
DCHFT	(1.3)	(10.4)	(9.4)	0.0	(6.0)	**(6.0)**

Forecast Outturn 24/25 £m	DCHFT
Forecast deficit driven by:	
Impact of Industrial Action	(0.1)
ERF above 107.2% to ICB	(2.1)
Inflation not in plan/FYE RPI contracts	(2.3)
Drugs pressures	(6.0)
NCTR/cost of cover	(4.1)
Efficiency Shortfall risk	(6.0)
Increased consumables/IMS TBC/computer licences	(1.4)
Agency plus other improvement offsets	3.7
CIP delivered YTD	7.2
Total Forecast Deficit Excl mitigations (worst case):	**(11.1)**
Potential Mitigations (best case):	
CIP delivery (low & med)	1.2
Insourcing FOT recovery	0.2
Further agency improvement stretch	0.4
Confirmed Covid spend review	0.6
ERF expected income 24/25 & 23/24	2.0
Income expected to match costs	0.8
VAT rebate	0.4
Cost controls - workforce, PO/non discretionary spend actions	0.5
Drugs savings realise	0.9
Accrual reviews & non contract income expected	0.7
2024/25 forecast, with mitigations	**(3.4)**
Planned Surplus/(Deficit)	**0.0**
Total 2024/25 forecast risk, with mitigations	**(3.4)**

Expanded Risk Adjusted Forecast continued:

Total 2024/25 forecast, with mitigations	**(3.4)**
Further Stretch:	
Federated model/system opportunities	1.0
Revised Total 2024/25 forecast, with mitigations	**(2.4)**
Further ICB agreed support noting route to £25m:	
Asset valuation/bal sheet review (min scope DCH)	1.0
Stretched performance	1.0
Total 2024/25 with mitigations	**(0.4)**
System adjustment	0.4
Total 2024/25 with mitigations	**(0.0)**

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Financial Position Update - February 2025
Industrial Action

Dorset County Hospital
NHS Foundation Trust

2024/25 Industrial Action
Costs incurred in June and the initial part of July supporting Industrial Action amount to £0.196m with a further £0.255m estimate of lost activity income. Of which, for July reporting purposes, £0.062m of net staff cost and an estimated £0.102m of lost activity income were incurred. For DCHFT, June & July 2024 the combined net cost & lost elective recovery activity is estimated at £0.4m. This total estimated cost covering the full industrial action period during June and July has been reported to NHS England (NHSE) as part of national reporting requirements. In M6 NHS England notified Trusts of their Industrial Action funding envelopes, Dorset County Hospital received £0.272m leaving an unfunded pressure of £0.137m.

2024/25 Industrial Action Staff Group	Junior Doctors £'000	Junior Doctors £'000	Total £'000
Strike Date	***27-30 Jun***	***1-2 July***	
Immediate backfill costs to cover services	*£118*	*£78*	**£196**
Offset by Salary Savings	*-£25*	*-£17*	**-£42**
Net Cost	***£92***	***£62***	**£154**
Number of Industrial Action Days	*3*	*2*	5
Estimate of Lost ERF Activity	*£153*	*£102*	**£255**
Net Cost & ERF Income Loss	**£245**	**£164**	**£409**
Estimated Cost Per Day £'000	£82	£82	£82

	£'000
Industrial Action partial funding received	£272
Net cost & ERF income loss due to IA	£409
Industrial Action funding shortfall/cost pressure	**-£137**

Rescheduled Elective Inpatients	6	4	**10**
Rescheduled Day Case Activity	77	51	**128**
Reschedule Outpatient Appointments	362	241	**603**

Financial Position Update - February 2025
Trust Wide Performance: Agency

NHS
Dorset County Hospital
NHS Foundation Trust

Pay Analysis - Agency

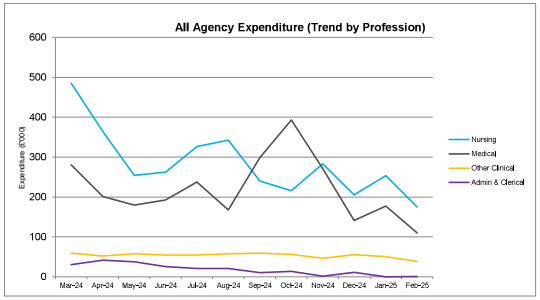
Agency costs equated to £0.3 million of actual expenditure in month against a plan of £0.8 million, showing a decrease from last month and the lowest it has been YTD.

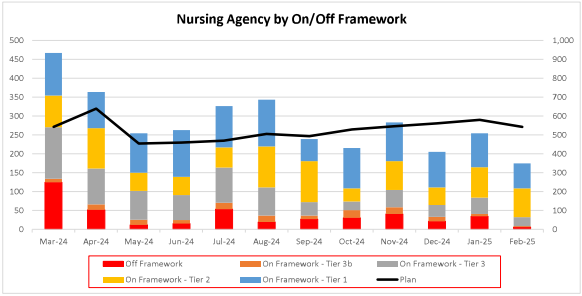
Agency expenditure hit the 3.2% of total pay NHSE target set for 2024/25 YTD.

Although there is continued improvement in agency expenditure, ED remains an area of focus to reduce spend, which is supported through the safer staffing and high cost agency working groups.

Agency reduction remains a high priority for the Trust noting expected achievement of the NHSE applied System spend cap of 3.2% of pay budget for 2024/25 and the mandation of no use of Off Framework from 1st July 2024 with a break glass procedure adopted to maintain essential safety only.

System collaborative workstreams including a 15% agency rate reduction being applied from 2nd January 2024 by all organisations which has driven the improved position in conjunction with a decrease in overall vacancies for the Trust. A further % rate reduction was applied as a system from the end of March 2024.





Agency Spend by Profession (£'000)	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Nursing	527	485	364	254	263	326	343	240	215	283	206	254	175
Medical	179	281	201	180	193	238	167	299	393	271	141	177	110
Other Clinical	82	59	52	58	55	54	58	59	56	46	56	50	39
Admin & Clerical	15	31	42	38	26	21	21	10	14	2	11	0	0
Totals 2023/24 & 2024/25 YTD	**802**	**856**	**659**	**530**	**536**	**639**	**589**	**608**	**679**	**602**	**414**	**481**	**323**

YTD Actual	YTD Plan	Variance
2,922	5,841	2,919
2,370	2,345	-25
583	701	118
185	338	153
6,060	**9,225**	**3,164**

Nursing Agency Category	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Off Framework	126	125	52	12	15	54	20	27	31	41	21	35	7
On Framework - Tier 3b	71	10	15	13	10	17	17	10	20	18	12	6	2
On Framework - Tier 3	148	136	94	77	66	93	74	35	23	45	31	43	23
On Framework - Tier 2	81	84	107	48	49	54	109	108	34	77	46	81	77
On Framework - Tier 1	105	113	96	104	123	109	123	59	107	102	94	89	66
Plan	543	543	640	454	460	469	506	493	530	546	562	581	543
Orders awaiting allocation	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals 2023/24 & 2024/25 YTD	**527**	**485**	**364**	**254**	**263**	**326**	**343**	**240**	**215**	**283**	**206**	**254**	**175**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	1.9%	3.2%
Off framework expenditure as % of total agency	2.0%	5.4%

Areas Using Nursing Agency Including Off Framework YTD (£'000)

Area	Off Framework	On Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	57	501	38	558	19%
Day Surgery Unit	8	264		271	9%
Moreton Ward - Respiratory	2	247		249	9%
Purbeck Wd	0	212	1	212	7%
Lulworth Ward	3	175	0	178	6%
Ilchester Integrated Assessmen	2	157	27	159	5%
Abbotsbury Ward	17	133	36	150	5%
Stroke Unit	15	134	2	149	5%
CRCU	47	92		139	5%
Fortuneswell Ward	1	115		116	4%
The Mary Anning Unit	2	114	3	116	4%
Kingfisher Ward	56	53	6	109	4%
SCBU	102	-		102	3%
Frailty SDEC	1	79		80	3%
Ridgeway Wd	0	63		63	2%
Evershot Ward	1	56		55	2%
Prince Of Wales	1	54		54	2%
Dch Dialysis	-	52		52	2%
Cardiology Care Ward	2	34		35	1%
Theatre Suites	-	31		31	1%
Surge Area	-	26		26	1%
SDEC	0	6		6	0%
Discharge Team	-	3		3	0%
Emergency Dept Nurse Practners	-	3		3	0%
B'Mth Dialysis	-	2		2	0%
Total Nursing Agency YTD	**315**	**2,607**	**113**	**2,921**	

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Financial Position Update - February 2025

Insourcing

Dorset County Hospital NHS Foundation Trust

Insourcing Narrative
The insourcing budget of £7.2 million is planned to; support the reopening of Weymouth Theatre, provide insourcing activity set via FPC at beginning of the year, fund substantive roles in ENT and Ophthalmology. All substantive posts are now recruited to including within theatres, however there is an additional Medinet team in place in Weymouth to assist with training of new recruits. This is however temporary and this support will cease once training is complete. Further executive approval to spend an additional £1.550m has been agreed to support delivery of 65 ww. Currently the forecast trajectory shows total spend of £9 m which is circa £0.2m above the allowable expenditure. Key discussions are taking place to ensure actions to bring back in line with plan and deliver in line with £8.8m target. The Trust is required to achieve a minimum of 104% of activity against the 2019/20 baseline, estimated delivery in December shows a trajectory of 114% achievement, although noting the associated non recoverable cost of delivering this activity.

	Actual Apr-24	Actual May-24	Actual Jun-24	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Forecast Mar-25	Forecast Outturn
Budget:	**788**	**788**	**905**	**827**	**827**	**654**	**457**	**450**	**445**	**445**	**446**	**212**	**7,243**
Spend:													
Breast	19	13	13	13	13	14							**85**
Cardiology	7												**7**
Dermatology	151	115	142	117	151	157	131	134	98	153	113	126	**1,589**
Endoscopy/Gastro	113	99	115	114	146	129	101	104	100	82	89	9	**1,203**
ENT	9	47	48	48	72	49	98	214	148	76	97	108	**1,016**
General Surgery	0	0	94	114	109	92	172	48	55	26	(10)	0	**699**
Gynaecology	95	99	83	78	129	83	76	74	61	54	24	0	**856**
OMF	152	174	120	33	114	110	119	63	108	55	124	194	**1,367**
Ophthalmology	26	44	31	90	35	35	18	59	4	0	4	4	**350**
Orthopaedics	52	83	62	52	88	78	43	97	62	89	104	104	**916**
Urology			2	32	48	16	13	5		0			**117**
Vascular						1				0			**1**
Pre Assessment						10	6	(15)		0			
Peads Surgery							33			0			
Theatre Staffing						102	202	135	82	82	81	82	**766**
Total spend	**625**	**674**	**712**	**691**	**906**	**875**	**1,012**	**918**	**718**	**618**	**626**	**627**	**9,003**
Surplus/(Deficit)	**162**	**114**	**193**	**135**	**(80)**	**(221)**	**(555)**	**(468)**	**(273)**	**(173)**	**(180)**	**(415)**	**(1,760)**

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Financial Position Update - February 2025
COVID Expenditure

Dorset County Hospital
NHS Foundation Trust

Covid Narrative
Covid spend has decreased slightly to fall back in line with prior months spend of c70k. Ongoing underspends have meant YTD total CIP from COVID is c£0.800 million. Covid funding has reduced for 2024/25 (from £2.3 million) and all areas will be reviewed for only reasonable and expected Covid related costs - some of which have further been identified this month (i.e. additional cleaning). The Trust has reviewed its external security provision and is in the final stages of recruiting to an internal provision, however there has been a spike of external usage in month due to challenging patients. This roaming usage ceased from 7th October 2023, with ward based insourcing security trailed during November. This has proven successful and with the exception of some mental health patient support, noting external ward costs have fallen.

	Description	2023/24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	YTD
Plan:		**£2,287**	**£211**	**£211**	**£209**	**£208**	**£205**	**£203**	**£199**	**£195**	**£190**	**£185**	**£179**	**£2,195**
Expenditure:														
Pay	Substantive	£282	£1	£1	£14	£34	£9	£9	£11	£10	£9	£9	£8	£89
	Bank	£108	£0	£3	£7	£0	£0	£0	£0	£4	£1	£1	£1	£14
	Agency	£1	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Pay		**£391**	**£1**	**£4**	**£21**	**£34**	**£9**	**£9**	**£11**	**£14**	**£10**	**£10**	**£9**	**£132**
Non-pay	Clinical Supplies and Services	£223	£32	£4	£22	£26	£52	£0	£91	£26	£26	£26	£26	£253
	General Supplies and Services	£0	£0	£0	£8	£5	£6	£4	£2	£2	£10	£3	£2	£28
	Establishment Expenditure	£6	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Other Non-Pay (security)	£472	£22	£21	£21	£23	£47	£15	£40	£14	£23	£41	£32	£203
	Premises and Fixed Plant	£162	£12	£12	£12	£3	-£12	£1	£0	£8	£0	£5	£0	£35
Total Non-pay		**£863**	**£65**	**£38**	**£62**	**£57**	**£93**	**£20**	**£133**	**£51**	**£59**	**£75**	**£60**	**£713**
Total Expenditure		**£1,254**	**£66**	**£41**	**£83**	**£91**	**£102**	**£29**	**£144**	**£65**	**£69**	**£85**	**£69**	**£845**
Total Surplus/(Deficit)		**£1,033**	**£145**	**£170**	**£126**	**£117**	**£103**	**£174**	**£55**	**£130**	**£121**	**£100**	**£110**	**£1,350**

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Financial Position Update - February 2025
Sustainability & Efficiency

NHS
Dorset County Hospital
NHS Foundation Trust

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is circa 5% which equates to £14.4 million for the financial year.

In month delivery of c£0.8 million has been achieved, £0.050 million coming from agency cost reduction of Off Framework and the remainder largely from COVID and finance review savings (£1.5 million YTD savings) and pay slippage. YTD delivery stands at c£7.2 million (including £3 million of agency cost - for Off Framework reduction). This is c£5.4 million behind plan YTD. £3.4 million of cost avoidance schemes have also been achieved YTD (Reduction of agency usage against 2023/24 levels).

£7.1 million has been planned as fully identified schemes and in progress.
The remaining £6.8 million of schemes have now been identified as high risk (47%) and are yet to deliver any savings. Theses schemes have been identified and linked to workforce reviews, non recurrent delivery opportunities, pay sickness review and productivity.

Efficiencies identified so far include further Covid reduction against plan, procurement savings, corporate savings, non recurrent slippage against existing planned budgets, agency spend reduction and pharmacy review savings.

This programme of work has been shared with the Dorset System with collaborative opportunities being actively assessed and reviewed with focus on flow, bed usage noting improvements to productivity are essential, supported by System partners.

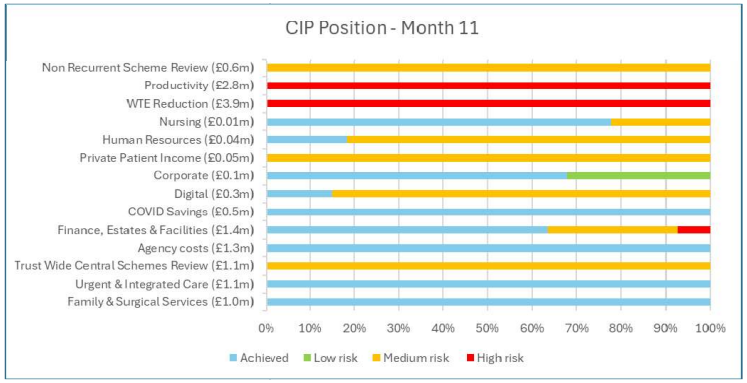
Efficiency by Division	Plan (excl Central Distribution)	Identified High Risk	Identified Medium Risk	Identified Low Risk	Total Identified
Family & Surgical Services	1,029		217	812	1,029
Urgent & Integrated Care	1,099		138	961	1,099
High Cost Agency & Off Framework Reduction	1,300			1,300	1,300
Finance, Estates & Facilities	1,350	100	647	603	1,350
Trust Wide Central Schemes Review	1,145		1,145		1,145
Non Recurrent Scheme Review	646		646		646
COVID Savings	500			500	500
Digital	339		339	-	339
Corporate	125			125	125
Private Patient Income	47		47		47
Human Resources	38		31	7	38
Workforce	24		24		24
Nursing	9		3	6	9
WTE Reduction	3,918	3,918			3,918
Productivity - CANDo etc	2,800	2,800			2,800
Grand Total	**14,369**	**6,818**	**3,237**	**4,314**	**14,369**
Total as at February 2024	**14,369**	**6,818**	**3,237**	**4,314**	**14,369**

Plan YTD	Actual YTD	% Achieved (FY Plan)
944	1,107	108%
1,019	1,253	114%
867	3,022	232%
1,161	857	63%
992	-	-
867	-	-
433	790	158%
287	51	0%
106	101	-
40		-
37	7	0
275		
14	7	77%
3,395		-
2,149	-	-
12,586	**7,195**	**50%**
12,586		

Scheme Status	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000
Delivered	3,085		478	3,632	**7,195**
Identified - in progress			90	0	**90**
Identified - not started				266	**266**
Identified Stretch Targets (High Risk):					
Workforce WTE Review	3,918				**3,918**
Property leases Review				100	**100**
Productivity		2,800			**2,800**
Total CIP 5%	**7,003**	**2,800**	**568**	**3,998**	**14,369**

Cost Avoidance Schemes	£ Avoidance YTD
Family & Surgical Services	**1,355**
Income - Non-Patient Care	-
Pay - Agency - reduce the reliance on agency	1,355
Pay - Establishment reviews	-
Urgent & Integrated Care	**2,008**
Income - Non-Patient Care	
Non-Pay - Procurement (excl drugs)	126
Pay - Agency - reduce the reliance on agency	1,860
Admissions Avoidance	22
Pay - Establishment reviews	-
Grand Total	**3,363**
Total as at November 2024	**3,363**

Efficiency Plan	£'000	%	No of Schemes
Recurrent			
Pay	5,205		17
Non Pay	1,972		22
Income	230		16
Total Recurrent	**7,406**	**52%**	**55**
Non Recurrent			
Pay	2,338		24
Non Pay	4,306		23
Income	319		10
Total Recurrent	**6,962**	**48%**	**57**
Grand Total	**14,369**		



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Financial Position Update - February 2025

Cash

Dorset County Hospital NHS Foundation Trust

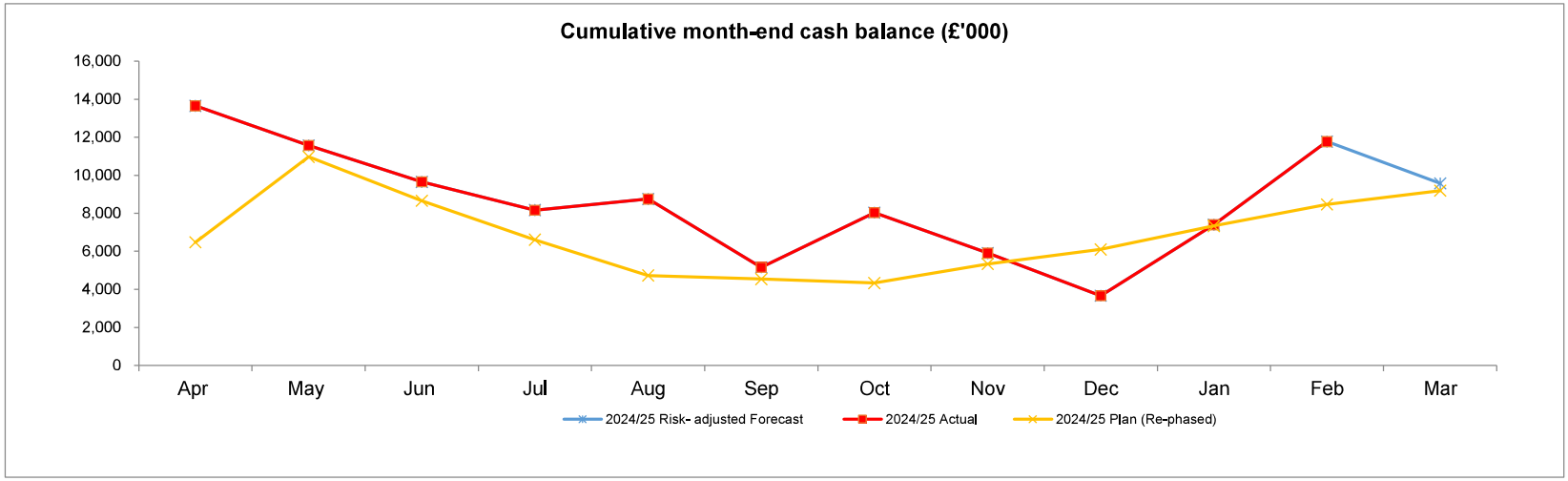
Cash Balance incl Forecast

The graph shows the trajectory of the actual year to date and forecast cash balance during the year, with identified direct intervention taking place to mitigate the shortfall in cash.

The cash position is currently £11.8 million at end of February, which is ahead of forecasted position of £6.3 million. Cash being £5.5m ahead of forecast relates income of £2.0m received from NHS Dorset for top up funding & ERF 2024/25, £0.9m new PDC funding for PLACE and timing of drawdown of PDC £2.1m to ensure cash in place ready to pay capital invoices. Active chasing of Aged Debt has brought in a further £0.5m of cash.

The Plan assumed full delivery of the efficiency programme, however due to year to date slippages against these schemes, the Risk-adjusted forecast highlights cash shortfalls if delivery of schemes is not achieved. The CFO is leading regular support meetings to deliver all low and medium rated efficiency schemes, in conjunction with expediated system conversations regarding options for cash support.

The Trust received the first instalment of revenue support funding in April totalling £1.5m which supports the repayment of working capital. A subsequent request was made to NHSE for a further £3.0m cash support for March given the risk-adjusted forecast modelling, however this was rejected by the national team on the basis that a funding allocation was due to the Trust from Dorset ICB. To alleviate the pressure, £5.7 million was received early from Dorset ICB in March for 2024/25 ERF to M12 and a further £2m system support was received from NHSE in March resulting in an improved March Risk-adjusted Forecast.



Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2024/25 Plan (Re-phased)	6,479	10,972	8,661	6,607	4,727	4,543	4,337	5,334	6,099	7,337	8,466	9,201
2024/25 Risk- adjusted Forecast												9,582
2024/25 Actual	13,650	11,566	9,660	8,164	8,752	5,158	8,037	5,901	3,664	7,399	11,776	

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Financial Position Update - February 2025

Capital

Dorset County Hospital
NHS Foundation Trust

Capital Programme Narrative
Capital expenditure year to date to the end of February was £18.6 million and behind plan by £5.3 million. Internally Funded schemes and donated schemes are overall ahead of plan at the end of February by £0.9 million. Digital and Medical Equipment Schemes were behind plan year to date due to timing of the purchase of replacement items. Estates schemes are ahead of plan year to date due to timings of expenditure on East Wing Theatres and Ridgeway Ward, which has carried over from 2023/24. There is a significant requirement for internally funded capital for both backlog works and medical device replacements, which is putting pressure on the programme of works as requests become urgent and unavoidable. All areas have provided an updated and prioritised list of works for review, including appropriate consideration and action. In September, the Trust received confirmation from NHS England of external capital funding for the Colposcopy Service totalling £0.6 million. In December the Trust received notification from NHS England of external capital funding for Critical Infrastructure Risk of £0.3 million. In January the Trust received notification from NHS England of funding of £0.9m for Place annd essential equipment Externally Funded capital expenditure was £5.5m behind plan due to timings of expenditure on New Hospital Programme (NHP) enabling works. Given the Trusts capital programme is over-subscribed, this is being closely monitored and overseen by Capital Planning & Space Utilisation Group (CPSUG) to ensure risks and priorities are managed appropriately throughout the year with all opportunities and slippage maximised. Due to the significant capital projects and level of high risk demands on capital the Trust is forecast to overspend against internal enveloped by £891k, onoing discussions are being had with Dorset ICB and Regional colleagues to usuage slippage of £891k from the IFRS 16 Leases envelope to offset this overspend. Baxter,Abi 02/04/2025 16:28:00 .

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2024/25			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Estates										
Chemotherapy Unit	50	545	(495)	1,833	1,638	195	1,932	1,932	1,932	0
East Wing Theatre	0	6	(6)	450	1,426	(976)	1,447	1,447	0	(1,447)
Estates Schemes	0	171	(171)	1,200	2,138	(938)	2,379	2,661	1,650	(1,011)
Digital Services										
Digital Schemes	152	159	(7)	2,072	1,582	490	1,641	1,641	2,291	650
Equipment										
East Wing Theatre Equipping	0	0	0	295	295	0	312	312	295	(17)
Other Equipment	100	69	31	1,118	752	366	364	364	1,272	908
Sub-Total Internally Funded Expenditure	**302**	**951**	**(649)**	**6,968**	**7,831**	**(863)**	**8,075**	**8,357**	**7,440**	**(917)**
Donated										
Other Donations	0	48	(48)	0	80	(80)	156	21	0	(21)
Chemotherapy Unit Refurbishment	80	0	80	400	316	84	324	459	480	21
Sub-Total Planned Donated Expenditure	**80**	**48**	**32**	**400**	**396**	**4**	**480**	**480**	**480**	**0**
IFRS 16 Lease Additions										
Warehouse	0	0	0	480	546	(66)	546	546	480	(66)
MSCP Lease remeasurement	0	0	0	1,000	266	734	263	355	1,000	645
CEF Lease remeasurement	0	0	0	600	408	192	408	408	600	192
One Dorset Pathology	0	0	0	0	0	0	0	0	250	250
Accommodation & Vehicle Lease Additions	0	20	(20)	150	267	(117)	270	280	150	(130)
Sub-Total Planned IFRS 16 Expenditure	**0**	**20**	**(20)**	**2,230**	**1,487**	**743**	**1,487**	**1,589**	**2,480**	**891**
Total Internal & Leased Capital Expenditure	**382**	**1,019**	**(637)**	**9,598**	**9,714**	**(116)**	**10,042**	**10,426**	**10,400**	**(26)**
Additional funded schemes										
NHP Development	0	30	(30)	758	1,259	(501)	1,511	1,511	758	(753)
NHP Works	2,000	1,054	946	8,000	1,975	6,025	2,435	2,435	12,819	10,384
NHP Enabling	0	0	0	4,660	4,501	159	4,837	4,837	4,660	(177)
Digital EHR Funding	91	43	48	609	486	123	843	1,093	1,093	0
CDC Funding	0	0	0	16	15	1	16	16	16	0
Mental Health UEC Funding	0	0	0	257	0	257	0	0	257	257
Colposcopy	0	122	(122)	0	213	(213)	530	608	0	(608)
Critical Infrastructure	0	0	0	0	0	0	300	300	0	(300)
Cyber Security	0	100	(100)	0	100	(100)	100	105	0	(105)
LED Lighting	0	0	0	0	0	0	42	42	0	(42)
PLACE & Essential Equipment	0	100	(100)	0	265	(265)	736	900	0	(900)
Inventory Management System (pending)	0	0	0	0	30	(30)	30	30	0	(30)
Total Externally Funded Capital Expenditure	**2,091**	**1,449**	**642**	**14,300**	**8,844**	**5,456**	**11,380**	**11,877**	**19,603**	**7,726**
Total Capital Expenditure	**2,473**	**2,468**	**5**	**23,898**	**18,558**	**5,340**	**21,422**	**22,303**	**30,003**	**7,700**
Expenditure as a % of Plan			100%			78%				74%

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Report to	DCH Board Part 1 8 April 2025 DHC Board Part 1 9 April 2025	
Date of Meeting	As above	
Report Title	Finance and Operational Plan 2025.26	
Prepared By	Claire Abraham, Deputy CFO DCH Sarah Day, Director of Operational Finance DHC	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Extra-ordinary Joint Board 24 March 2025	
Action Required	**Approval**	
	Assurance	
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Identify risks and mitigations associated with plan delivery, financial sustainability	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	System financial plan delivery	

Executive Summary

Integrated Care Systems (ICSs) and providers are required to a submit a financial and operational plan to NHS England (NHSE) for financial year 2025/26 on 27th March 2025. Whilst this has been communicated as a final plan submission, it is anticipated that a further submission will be required on 24th April 2025. The attached summary details that which was submitted on 27th March. Plans continue to evolve and a further Extra-Ordinary Joint Board will be convened in the week of 21st April prior to the final April submission to sign off the plan and the Board Assurance document (see appendices for current draft).

The proposed financial plan submission for the Dorset system as at 27th March 2025 is a breakeven position, which is an improvement from the February draft plan submission of an £80.9m deficit. The improvement relates to alignment of system plan assumptions, changes to assumed income, and Integrated Care Board (ICB) commissioning intentions.

The proposed plan includes a deficit of £12.8m for Dorset County Hospital (DCH) and a surplus of £13.1m for Dorset HealthCare (DHC). This includes the reinstatement of provider support of £18.4m from the ICB to DCH, as received in 2024/25, although agreement of provider and ICB positions, including the treatment of this provider support, will need to be confirmed ahead of April plan submissions.

The plan includes core 5% provider cost improvement programme target, along with reinstatement of non-recurrent efficiency delivery from 2024/25, as follows:

Organisation	Dorset HealthCare	Dorset County Hospital
	£'000	£'000
5% Efficiency target	22.4	18.1
Reinstate 24/25 NR efficiency delivery	13.1	7.9
Total 25/26 Efficiency Requirement	**35.5**	**26**

Workforce plan reductions in DCH of 164 and DHC of 230 are included in the plan. This may change ahead of the final April submission pending further triangulation of workforce and finance returns.

Further analysis and challenge will take place across the Dorset system ahead of the April 2025 plan submission to focus on deliverability, along with finalising organisational positions within the system breakeven plan. System and organisational workforce plans will also be fully triangulated ahead of the April submission to ensure a clear trajectory in line with planning guidance.

A Board Assurance Framework is also required to be considered by Trust Boards which confirms assurance around plan submissions. The Assurance Statements were considered by the Joint Board on 24th March 2025 and it was agreed that further evidence would be supplied in April to allow for formal sign off. Subsequent to this meeting the ICB asked for our draft submission which was required in addition to the System submission. The submissions seen in Appendix 1 (DCH) and Appendix 2 (DHC) were therefore drafted building on the comments made at the Joint Board. Further iterations will be shared at the planned Joint Board in the week beginning 21 April 2025 alongside supporting evidence.

Recommendation

Both Boards are requested to review the enclosed as information only at this stage as this represents the submission made 27th March 2025 and was agreed at the Extra-Ordinary Board on 24th March.

Dorset County Hospital
Dorset HealthCare

2025/26 Operational Planning Update

DCH Trust Board 8 April 2025
DHC Trust Board 9 April 2025

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2024/25 year end System finance position

Dorset County Hospital NHS Foundation Trust

£'m variance to plan	System	DCH	DHC	UHD	ICB
Underlying position	**-44**	**-6**	**0**	**0**	**-38**
Additional ERF	9		8	1	
ERF included in position	-4		-3	-1	
Asset revaluation/ balance sheet reviews	7	1	4	2	
CDC productivity/ workforce controls	3			3	
Stretched performance	4	1	1	1	1
Target forecast	**-25**	**-4**	**10**	**6**	**-37**
System adjustment	0	4	-10	-6	12
March NHSE adjustment	13	13			
Final forecast	**-12**	**13**	**0**	**0**	**-25**

- The Dorset system is anticipated to deliver a year end position £12m adverse to plan.
- An additional £13m of national funding has been received by the system in month 12 to improve the position from £25m to £12m adverse.
- In order to support the DCH cash position, system partners have agreed to recognise this funding, and the corresponding cash and revenue, in DCH.

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – March submission

Dorset County Hospital NHS Foundation Trust

2025/26 Plan Development	ICB £m	DCHFT £m	DHC £m	SWASFT £m	UHD £m	System Total £m
Scenario 2	**20.8**	**(31.2)**	**13.1**	**-**	**(32.4)**	**(29.9)**
ICB Bridge rigour review/CHC Stretch	5.0					5.0
Investments & cost pressures review	10.0					10.0
Further Commissioning review	9.0					9.0
Pathway changes	5.9					5.9
Scenario 3	**50.6**	**(31.2)**	**13.1**	**-**	**(32.4)**	**0.0**
Reinstate NR system allocation	(42.4)	18.4			24.0	-
27th March presentational plan	**8.2**	**(12.8)**	**13.1**	**-**	**(8.4)**	**0.0**

- Through further stretch of CHC, pathway changes within the system, and further review of commissioning, a breakeven position is determined to be achievable.

- For presentational purposes in the March submission, the “non recurrent” system support received through 24/25 planning is re-instated to reallocate funding to acute Trusts, however agreement on this allocation will be determined ahead of the April submission.

- Whilst the bridge from £42.1m (scenario 1) to breakeven (scenario 3) shows benefits in the ICB, rapid system analysis will take place ahead of the April plan submission to ensure savings are recognised in the appropriate organisation. This will be achieved through:
  - A further deep dive into provider and ICB plans to identify opportunities. Any residual gap will be achieved through a system commissioning review.
  - Review of additional non recurrent opportunities in 24/25 and 25/26.
  - Full workforce triangulation with financial plans across the system.
  - Resolution of the £42.4m acute funding issue.

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – Financial assumptions

Dorset County Hospital NHS Foundation Trust

Income assumptions:

- Provider block income uplifted by 4.15%, before a 2% national efficiency applied (i.e. a net 2.15% uplift)
- Elective recovery fund (ERF) capped at c. 91% of 24/25 levels. Plan assumes fair share of ERF using previous year's baseline (incl. c. £5m ERF in DHC position not present in previous years)
- Service development fund (SDF) at reduced levels from 24/25, with commissioning review of service funding
- Mental Health Investment Standard (MHIS) funding protected
- Acute provider support provided in 24/25 included in provider distribution, with final treatment to be agreed in April submission
    - £18.4m DCH, £24m UHD

Cost assumptions:

- Pay uplift 4.7% including anticipated agenda for change increase and increased NI contributions
- Efficiency required 5% (c. £18.1m DCH, £22.4m DHC), plus additional c. 3% to mitigate non-recurrent efficiency delivery in 2024/25 (c. £7.9m DCH, £13.1m DHC)
- Assuming no investments made other than quality and safety requirements (supported by EQIA process)
- Pressure will exist on non-pay contracts, drug expenditure and out of area placements (DHC)

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – Performance

Dorset County Hospital NHS Foundation Trust

Programme	Metric	Expectation
Elective	RTT 18 weeks wait	>= 65% in March 26 nationally. Each provider minimum 6% improvement
	RTT 1st OPA wait	>= 72% in March 26 nationally. Each provider minimum 5% improvement
	52ww	<1% of total waiting list by March 2026
Cancer	62d Cancer	Improve to 75% by March 26
	28d FDS	Improve to 80% by March 26
UEC	A&E 4 hr	Improve to >= 78% in March 26 and a higher % of patients admitted, transferred & discharged from ED within 12 hours across 25/26 compared to 24/25
	Cat 2	Improve to average of 30 mins across 25/26
Primary Care	GP Access	Improve patient experience as per ONS Health Insights Survey
	Dental Access	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more
Mental Health & Learning Disability Care	Length of Stay	Reduce average length of stay in adult acute mental health beds
	CYP Access	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019
	LDA Inpatients	Reduce reliance on mental health inpatient care for people with a learning disability & autistic people, delivering a minimum 10% reduction
Finance/ Productivity	Financial Position	Deliver a balanced net system financial position for 25/26
	Agency & Bank	Reduce agency expenditure as far as possible, with a minimum 30% agency & 10% bank reduction on current spending for all systems
	Activity	Close the activity/WTE gap against pre-Covid levels (adjusted for Case Mix)
Maternity	Safety	Improve safety in maternity & neonatal services, delivering key actions of the 'Three Year Plan'
Health Inequalities & Prevention	Core20 PLUS5	Reduce inequalities in line with theCore20PLUS5 approach for adults and children and young people
	Prevention	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – Performance DCH

Dorset County Hospital NHS Foundation Trust

- Performance plan will achieve all performance trajectories as stated in the 2025/26 Operating plan
- Includes a 1.8% increase in A&E attendances, taking account of countywide reconfigurations expected
- Assumes 4% referral growth, allowing for ICB patient choice promotion and delivering commissioning for sustainability programme.
- Deliver 110.5% of the activity volumes delivered in 2023/24

VS 23/24	April	May	June	July	August	September	October	November	December	January	February	March	Full year
Elective Inpatients	111.01%	103.20%	99.78%	114.19%	119.63%	110.62%	126.43%	99.33%	110.44%	114.11%	114.81%	108.17%	110.51%
Day Case	102.40%	99.98%	105.73%	104.63%	124.10%	115.57%	121.07%	116.20%	112.20%	118.40%	113.22%	97.26%	110.58%
Outpatient Procedures	101.68%	112.98%	111.49%	111.32%	100.55%	104.55%	121.76%	108.83%	130.64%	110.20%	108.55%	110.96%	110.56%
New Outpatient Excluding Procedures	117.04%	108.04%	111.50%	107.04%	117.68%	110.75%	112.89%	102.53%	114.11%	106.34%	110.01%	111.53%	110.52%

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – Performance DCH

Dorset County Hospital NHS Foundation Trust

Metric		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
A&E: 4 hour wait	plan	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%
	actual												
RTT: Total Waiting List	plan	21,542	21,594	21,649	21,710	21,762	21,820	21,880	21,933	21,988	22,043	22,096	22,153
	actual												
RTT: 52wk wait	plan	431	410	390	369	348	327	306	285	286	265	243	222
	actual												
RTT: 52wk cohort % of Waiting List	plan	2.00%	1.90%	1.80%	1.70%	1.60%	1.50%	1.40%	1.30%	1.30%	1.20%	1.10%	1.00%
	actual												
RTT: % patients waiting <18wks	plan	58.70%	58.70%	58.70%	59.00%	59.50%	60.00%	60.50%	61.00%	61.00%	61.50%	62.00%	62.80%
	actual												
RTT: % patients waiting <18wks for 1st Activity	plan	63.13%	64.00%	65.00%	66.00%	66.00%	67.00%	68.00%	69.00%	69.00%	69.00%	69.50%	70.30%
	actual												
RTT: 52wk wait CYP	plan	0	0	0	0	0	0	0	0	0	0	0	0
	actual												
PIFU	Plan	5.00%	5.00%	5.00%	6.00%	6.00%	6.00%	7.00%	7.00%	7.00%	8.00%	8.00%	8.00%
	actual												
Cancer: 28 days FDS	Plan	75.07%	75.04%	75.06%	75.89%	76.65%	76.23%	77.51%	77.17%	75.74%	80.00%	80.00%	80.06%
	actual												
Cancer: 31 day DTT (combined)	Plan	90.83%	91.56%	90.95%	92.17%	92.82%	94.15%	95.65%	95.56%	95.77%	95.93%	96.28%	96.12%
	actual												
Cancer: 62 RTT (combined)	Plan	70.08%	71.43%	70.00%	71.03%	72.90%	72.88%	72.66%	76.22%	70.97%	75.91%	75.91%	75.54%
	actual												

2025/26 planning – Workforce

Dorset County Hospital 25/26 Workforce Plan:

Category	25/26 Opening WTE	25/26 Closing WTE	WTE Planned Reduction	%
Substantive	3,270	3,185	85	3%
Bank	200	180	20	10%
Agency	45	32	14	30%
Indicative further Corporate reduction		-45	45	
WTE Indicative Total Plan Reduction	**3,515**	**3,352**	**164**	**5%**

Dorset HealthCare 25/26 Workforce Plan:

Category	25/26 Opening WTE	25/26 Closing WTE	WTE Planned Reduction	%
Substantive	5,783	5,613	170	3%
Bank	328	298	30	10%
Agency	83	53	30	36%
WTE Total Plan Net Reduction	**6,194**	**5,964**	**230**	**4%**

Whilst there is broad triangulation of workforce numbers to the financial position, headline triangulation takes place at a system level, with further analysis to take place ahead of the April submission.

Workforce plans and assumptions are as follows:

- Ongoing focus to reduce headcount including support services recovery to April 2022 levels per national guidance
- Minimum 10% bank reduction per guidance
- Minimum 30% agency reduction per guidance

- DCH overall 164 WTE reduction planned – 130 WTE substantive (85 + indicative 45 from corporate stretch), 20 WTE Bank (10%) and 14.5 WTE agency (30%)
- DHC net reduction of 230 WTE across substantive, bank and workforce

Dorset HealthCare University NHS Foundation Trust

Efficiency targets

Dorset County Hospital NHS Foundation Trust

Organisation	Dorset HealthCare	Dorset County Hospital
	£'000	£'000
5% Efficiency target	22.4	18.1
Reinstate 24/25 NR efficiency delivery	13.1	7.9
Total 25/26 Efficiency Requirement	**35.5**	**26**

- By reinstating the 2024/25 non recurrent efficiency delivery for each organisation, a further £13.1m requirement and £7.9m for DHC and DCH respectively (combined £21m improvement), broadly equating to a further 3% in addition to the 5% core target
- This 3% will be found by transformational means including Future Care, Integrated Neighbourhood Teams (INTs) and subsidiary opportunities

Dorset County – Summary 25/26 Efficiency Position

Dorset County Hospital NHS Foundation Trust

Area	5% of Operating Expenditure £'000	5% Corporate Stretch Commitment £'000	Total 25/26 Efficiency Target £'000	Identified R £'000	Identified NR £'000	Total Identified £'000	Unidentified £'000
Urgent & Integrated Care	5,757	-	**5,757**	800	200	1,000	4,757
Family & Surgical Services	5,347	-	**5,347**	556	824	1,380	3,967
Finance	785	785	**1,570**	1,463		1,463	107
Estates & Facilities	1,403	1,403	**2,806**	2,806		2,806	-
Operational Support	302	302	**604**	302		302	302
Digital	347	347	**694**	510		510	184
HR & Workforce	276	276	**552**	427		427	125
Corporate & Commercial	266	266	**532**	412		412	120
Director of Nursing	119	119	**238**	184		184	54
Central Schemes - pending distribution				4,014	3,320	7,334	- 7,334
Totals	**14,602**	**3,498**	**18,100**	**11,474**	**4,344**	**15,818**	**2,282**

- The overall target includes Corporate stretch to 10% with operational areas at 5% target requirement
- Currently £15.8m of the £18.1m has been identified (87%) with £2.3m to be identified, noting the commitment from Corporate areas to deliver the 10% total in full
- £11.5m is deemed recurrent (63%) with £4.3m non recurrent (37%)

Dorset County – Central Schemes

Dorset County Hospital NHS Foundation Trust

Central Schemes:	R £'000	NR £'000	£'000
Productivity		1,784	
Pay Slippage (NR review 24/25)	703		
Drugs	800		
Reduce Bank Staffing (10% stretch as per guidance)	1,158		
Reduce Agency Staffing (10% stretch guidance)	790		
Reduce Agency Staffing (20%)	563		
Reduction of Locums		500	
Medical Additional Sessions		411	
COVID Savings		500	
Postage		75	
Paperless review		50	
Central Schemes Total	**4,014**	**3,320**	**7,334**

- To support triangulation and avoid duplication, Trust wide schemes amounts are held centrally and will be reallocated to local areas through setting budgets

Dorset HealthCare University NHS Foundation Trust

Dorset HealthCare – Summary 25/26 Efficiency Position

AREA	Corporate Savings 10% £'000	Temporary Workforce Reduction & Ops Efficiency £'000	Non Recurrent Additional Slippage £'000	25/26 Efficiency Target £'000	Identified R £'000	Identified NR £'000	Unidentified £'000
ICS		2,584	1,791	4,375	1588	1,813	974
MH & CYP		3,230	2,239	5,470	1655	1,547	2,268
Medical		2,157	404	2,561	2157	404	
Finance	413			413	413	0	
Estates	1,994			1,994	1,994	0	
P&C	1,015			1,015	1,015	0	
N&Q	823			823	823	0	
Strategy & IT	1,577	220		1,797	1,797	0	
Corporate	166			166	166	0	
Central Schemes - Pending Distribution				3,795		1,500	2,294
Totals	**5,988**	**8,191**	**4,434**	**22,408**	**11,608**	**5,264**	**5,536**

- Total identified efficiencies equate to £16.9m (75%) with £5.5m unidentified (25%)
- DHC central schemes identified of £1.5m relate to interest received and salary sacrifice schemes
- All corporate areas have committed to delivering the 10% efficiency, noting savings are currently assumed to be recurrent
- The target is for 70% efficiencies to be recurrent of which 70% will be in pay costs

2025/26 planning – DCH Essential Investments

Dorset County Hospital:

The following schemes have been identified as meeting essential quality and safety requirements and have been subject to a robust EQIA process

- Ophthalmology patients lost to follow up £0.170m

- Registered Nursing Degree Associates £0.065m – provides a one-on-one replacement of those due to qualify in 2025, cost of backfill when on placements

- Special Care Baby Unit £0.060m – alternative skill mix to address night shift highest area of risk to include 1x B6 night shift 7 days per week

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – Other considerations

Dorset County Hospital NHS Foundation Trust

Dorset County Hospital:

- Continued focus on cashflow management to ensure cash risk is understood with appropriate mitigation in place
- Treatment of ‘non recurrent’ funding for acute provider Trusts to be finalised
- Effective triangulation of all workforce, activity and finance plans

Dorset HealthCare:

- Protecting investment into Mental Health
- Investment into community services and out of hospital care
- Effective triangulation of all workforce, activity and finance plans

Dorset HealthCare University NHS Foundation Trust

2025/26 planning – Key Risks

Dorset County Hospital NHS Foundation Trust

- Financial position not accepted by NHSE
- Scale, deliverability and pace of efficiencies required
- Delivery of operational targets (i.e. Elective Recovery Fund, no reason to reside)
- Workforce requirement to reduce headcount
- Cash position in DCH

2025/26 planning – Recommendations

The Dorset County Hospital and Dorset HealthCare Boards approved the respective Trust's 25/26 operational planning submission, along with system position, as follows:

- Dorset system break even plan, noting detailed workforce and efficiency validation with further submission planned for 24th April 2025

- Dorset County Hospital deficit financial position £12.8m, including:
  - A 5% efficiency target (£18.1m), with a further 3% stretch (£7.9m), total £26m
  - 110.5% Elective Recovery Fund trajectory
  - Workforce plan reduction of 164 WTE
  - Agreement of the 3 investment requests

- Dorset HealthCare £13.1m surplus position, including
  - A 5% efficiency target (£22.4m), with a further 3% stretch (£13.1m), total £35.5m
  - Workforce plan reduction of 230 WTE

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- Approved to submit plans in line with national timetable 27th March 2025
- Delegated authority for CEO and CFO to agree amendments to plan, with changes communicated to Board ahead of submission provided at Joint Board 24 March 2025
- Consideration of statements in section B of Board Assurance Framework (Appendix 1 and 2) were undertaken and a draft submission made to the ICB in support of the System plan

Section B: Provider Assurance

Dorset County Hospital NHS Foundation Trust 26 March 2025

The Board were made aware of the requirement to submit the Board Assurance Framework to the ICB, and the expectation was that this would be with the April submission by which time the expectation was that all assurances would be in place to enable a positive statement to be made for each Assurance Statement. Therefore, the statements below reflect the current position regarding information considered by the Board as at 25 March 2025 but the statements themselves have not yet been approved by the Board.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	In progress	On 11 February 2025 the Board received a Finance and Planning update. This was shortly after the release of the Planning Guidance on 30 January 2025. Key headlines for 2025/25 planning were outlined, including the operational, workforce and financial requirements. Financial assumptions, capital headlines were included. On 24 March 2025 the Finance and Performance Committee and Board considered the Financial and Operational Plan March submission. This outlined the movement from the 27 February 2025 submission and the proposed 27 March 2025 submission. The report included financial, operational

		and workforce assumptions; efficiency targets; and key risks. It was noted that all schemes had not yet been subject to Quality Impact Assessment (see below – in progress). There is a plan to breakeven, but it is recognised that further work will be required following submission on 27 March 2025 and ahead of the final submission to NHS England on 24 April 2025. This work includes: • Full workforce triangulation • Stress testing opportunities and accuracy of data in opportunities • Plans to establish governance to manage the delivery of the programmes
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	In progress	As noted above we are developing the governance to manage the delivery of the programmes. We do have a new (Equality and Quality Impact Assessment) EQIA process in place and dates are being diarised for the CIP EQIAs, so these plans have not yet been through the process. The three provider Chief Medical Officers led the clinical prioritisation work, but this has not been to the Quality Committee with assurance then provided to Board.

Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	In progress	This will be completed as part of the EQIA process, and the prioritisation plans will be reviewed by the Board prior to the April submission.
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	In progress	We do have a new (Equality and Quality Impact Assessment) EQIA process in place and e dates are being diarised for the CIP EQIAs, so these plans have not yet been through the process. The three provider Chief Medical Officers led the clinical prioritisation work, but this has not been to the Quality Committee with assurance then provided to Board.
The organisation's plan was developed with appropriate input from and engagement with system partners.	In progress	The plan has been developed as a system with full partner engagement throughout. Engagement will continue as we move towards the April submission.

Assurance statement	**Confirmed (Yes / No)**	**Additional comments or qualifications (optional)**
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	In progress	The Board has received assurance that the plan has been developed to align with the national NHS priorities for 2025/26. Further work is required to provide additional assurance in respect of the national delivery plan

		‘checklists and use of benchmarking to identify unwarranted variation / improvement opportunities
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation’s operational, workforce and financial plans.	In progress	Further work is required to provide additional assurance in respect of the national delivery plan ‘checklists and use of benchmarking to identify unwarranted variation / improvement opportunities
The Board is assured that any key risks to quality linked to the organisation’s plan have been identified and appropriate mitigations are in place.	In progress	On 24 March 2025 the Finance and Performance Committee and Board considered the Financial and Operational Plan March submission. This outlined the movement from the 27 February 2025 submission and the proposed 27 March 2025 submission. The report included financial, operational and workforce assumptions; efficiency targets; and key risks. It was noted that all schemes had not yet been subject to Quality Impact Assessment (see below – in progress). There is a plan to breakeven, but it is recognised that further work will be required following submission on 27 March 2025 and ahead of the final submission to NHS England on 24 April 2025. This work includes: • Full workforce triangulation • Stress testing opportunities and accuracy of data in opportunities

		• Plans to establish governance to manage the delivery of the programmes
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	In progress	There is a plan to breakeven, but it is recognised that further work will be required following submission on 27 March 2025 and ahead of the final submission to NHS England on 24 April 2025. This work includes: • Full workforce triangulation • Stress testing opportunities and accuracy of data in opportunities • Plans to establish governance to manage the delivery of the programmes

Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meeting held on Monday 24 March 2025

Chair	Frances West
Executive Lead	Nicola Plumb, Chief People Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Received the Staff Survey Results which were overall positive for both DCH and DHC. • Received the Gender Pay Gap reports • Received the Equality, Diversity and Inclusion annual report for DCH • Received the draft Joint Strategy Enabling People Plan

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

Workforce KPI dashboard (Joint)

Dorset County Hospital:

- Sickness of staff reduced (to 4.45%) throughout January and February. The report showed 9% turnover and 3% vacancy rates and showed good progress in the reduction of agency use. DCH are expected to meet the planned enrolment figures for apprenticeships. However, DCH appraisal figures recorded need to be investigated.

Dorset Healthcare:

- DHC reported marginal changes such as decreases in mandatory training and sickness rates and increases in appraisal compliance. DHC Estates and Facilities pilot has been reported as successful. Total staff turnover for previous 12 months is 9%.

Gender Pay Gap Report

Dorset County Hospital:

- 9% year on year reduction to the gender pay gap, in favour of female staff. DCH have seen an increase in females at senior positions as well as an increase in the median hourly work rate. The report detailed steps to maintain this position and work towards closing the gap further.

Dorset HealthCare:

- Positive decrease in the gender pay gap (1.95% gap) which is a consistent reduction over the last 6 years, mainly due to median pay. Continuation of work to reduce the gap further; looking into the female representation on recruitment and selection panels.

Equality Diversity and Inclusion Annual Report (DCH)

- Inclusion and Belonging Strategy has been implemented. Tracking EDI related metrics is improving. There is work to be done around ethnicity and disability pay gaps and their representation across the organisation, particularly in higher bandings. Slight implications for bank staff – the report focuses mainly on employed staff.

Joint Strategy Enabling Plans – People Plan (Joint)

- Strategic objectives have been set and aims to focus on people's experiences, belonging, skills, and capabilities whilst drawing on our current data for insights. The main priority for year 1 is for the People Plan to be directly connected to operational activities, as well as focussing on emotional wellbeing of staff. An updated draft will be discussed at the next meeting.

Annual Staff Survey Results (DCH)

- Increase in response rate this year (46%) with staff engagement being significantly higher than across the sector. Results show significant improvement in 5 out of 7 people promise elements and 1 of 2 themes. Ranked 3rd in region for recommended place to work. 18.8% increase in staff reporting discrimination, which will be investigated. Areas to focus on are appraisals, work pressures and near misses & conflicting demands.

Annual Staff Survey Results (DHC)

- Decrease in response rate. DHC were above average in 6 out of 7 people promise elements and a decline in 1 (always learning), with an overall positive result. Most changes are marginal (not statistically significant). Improvement for equality and diversity and staff morale. Decreases for inclusion & compassion, autonomy & raising concerns, career development, staff motivation and work pressures. There will be ongoing work with HR Business Partner's around the 10 lowest-scoring items.

Quarterly Guardian of Safe Working Report (DCH)

- 64 exception reports, 3 of which were immediate safety concerns, and the majority were related to working shift patterns.

Quarterly Guardian of Safe Working Report (DHC)

- 10 reports raised between September - October 2024 (all have now been closed). 6 were related to breaching 5hrs continuous rest, 2 related to a busy weekend on call.

Developing Workforce Safeguards Report (DCH)

Developing Workforce Safeguards Report (DHC)

- Self-assessment report which has partial assurance for recommendations 7 (workforce plans) and 12 (quality impact assessments). The issue of partial compliance is being addressed separately to this meeting.

Policy Status Report (DHC)

- There will be a quarterly Policy Status Report and the process for this is underway (with a few things that need to be finalised before).

Higher Level Responsible Officer Report and Action Plan (DHC)

- Report shows that there is adequate resourcing for appraisals. The HLRO Reports are in the process of aligning with DCH, with discussions of a joint ROAG to start next month.

Update report: Mutually Agreed Resignation Scheme (MARS) (Joint)

- The outcome of MARS did not achieve the desired reductions. Suggestions of re-running the MARS scheme, with more transparency. Reports from patient-facing staff that the MARS felt unfair due to being told it was unlikely their applications would be accepted.

Assurance reports from below sub-groups of the People and Culture Committee in Common

DCH:

- Partnership Forum
- Equality, Diversity, Inclusion and Belonging Steering Group
- Local Negotiating Committee

DHC:

- Workforce Wellbeing Group
- Equality, Diversity, Inclusion and Belonging Steering Group
- Trade Union Partnership Forum

Decisions made at the meeting

- Approval of the Gender Pay Gap Report (DCH)
- Approval of the Gender Pay Gap Report (DHC)
- Approval of the Equality, Diversity and Inclusion Annual Report (DCH)
- Approval of the Joint Strategy Enabling Plan – People Plan
- Approval of Developing Workforce Safeguard Report (DCH & DHC)

Issues / actions referred to other committees / groups

- Nil

Quoracy and Attendance				
	23/09/2024	25/11/2024	27/01/2025	24/03/2025
Quorate?		Y	Y	Y
Frances West	Y	Y	Y	Y
Dawn Dawson	Y	Y	Y	Y (Left after 15 mins)
Alastair Hutchison	N	Y	N	
Rachel Wharton				Y
Lucy Knight			Y	Y
Suresh Ariaratnam	N	Y	Y	Y
Eiri Jones	Y	Y	Y	Y
Margaret Blankson	Y	Y	N	Y
Nicola Plumb	Y	Y	Y	Y
David Clayton-Smith	Y			

Report to	DCH Board of Directors	
Date of Meeting	8th April 2025	
Report Title	Gender Pay Gap Report (GPG) for the year 2023-2024 (DCH)	
Prepared By	Melanie Harris, HR Manager	
Approved by Accountable Executive	Nicola Plumb, Chief People Officer	
Previously Considered By	Senior Leadership Group 20th March 2025 People and Culture Committee in Common 24th March 2025	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	
Financial	No implications	
Statutory & Regulatory	GPG is an annual statutory requirement under the Equality Act 2010.	
Equality, Diversity & Inclusion	This report is one of the annual reports aligned to the People Promise. We produce the report each year as a statutory requirement and to focus our actions with the intention of closing the gender pay gap.	
Co-production & Partnership	No implication as the data is Trust specific	

Executive Summary

Gender Pay Gap (GPG) reporting is a requirement under the Equality Act 2010 and is always retrospective based on data from the previous year. As an organisation that employs more than 250 people and listed in Schedule 2 to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, we must publish and report specific information about our gender pay gap.

The Gender Pay Gap is not the same as unequal pay. The Gender Pay Gap can be simplified by understanding that we have more men than women in higher paid roles. Dorset County Hospital's Median Gender Pay Gap in 2023-2024 was 1.43% in favour of women. This represents an improvement on last year's reported figure of 7.65% in favour of men for the period 2022-2023. It is also the lowest reported figure over the last 6 years.

At Dorset County Hospital, our figures conclude that women earn £17.53 as the median hourly pay and that men earn £17.29. When comparing this, women's median hourly pay is 1.43% higher than men's.

Overall, like many organisations Dorset County Hospital still has a gender pay gap in favour of men in some pay bands. As a Trust we will continue to look at ways in which we can close the gap through the actions that are outlined in our People Plan.

Recommendation

The Board are requested to: Receive the report for **approval**.

Gender Pay Gap (GPG) Report for the year 2023-2024

1. Introduction

1.1. The gender pay gap can be defined as the difference between the median hourly earnings of men and of women. This is distinct from equal pay, which refers to men and women in the same job earning an equal wage.

1.2. Median and mean is what we are required to report on. Median is the middle value of the arranged set of data. Mean is the total of the numbers divided by how many numbers there are.

1.3. The data aims to collate a basic under understanding of the gender pay balance and structure within an organisation by comparing the hourly pay of the middle ranking man and the middle ranking women.

1.4. Our Gender Pay Gap Report for 2023/2024 contains these elements:

- The specific information published on the government website for the snapshot on 31st March 2024.
- An analysis of the pay gap across specific staff bands within Dorset HealthCare.
- Summary of the causes of our Gender Pay Gap and recommendations for future action to support reducing the gap where possible, considering the data is from 31st March 2024.

1.5 The Trust is required to report on six basic calculations:

- mean gender pay gap;
- median gender pay gap;
- mean bonus gender pay gap;
- median bonus gender pay gap;
- proportion of males and females receiving a bonus payment;
- proportion of males and females in each quartile band.

1.6 The data reported is based on:

- gross ordinary pay;
- bonus pay;
- in the relevant pay period;
- by the snapshot date.

1.7 As with any data analysis, the most critical aspect of the process is not just about reviewing the results but being clear about what needs to be done differently in future.

2. Main narrative

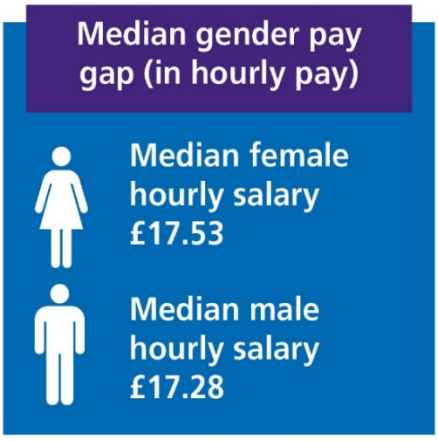
2.1. Our Gender profile in Dorset County Hospital on 31st March 2024, shows that the workforce consisted of **2939** women and **1011** men inclusive of bank workers. It's important to note that our bank worker data can vary considerably year on year due to the snapshot taken as at 31st March and the number of bank workers who have been active and paid on that date.

2.2. The table on the next page shows the median and mean hourly rate in Dorset County Hospital over the last 5 years. It also includes data in relation to bonus payments which for GPG calculations relate to Clinical Excellence Awards (CEA) only. Traditionally, these recognise and reward NHS Consultants in England, who perform over and above the standard expected of their role. Awards are given for quality and excellence, acknowledging expectational personal contributions. It's worth noting CEAs have now been incorporated into overall pay so cease to exist. However, a few contractual CEAs will remain in place for some longstanding consultants across the NHS which may see a continuation of the disparity in medics pay.

2.3. In comparison to last year, the rates have mostly moved in a positive position with an improvement across mean and median hourly pay as well as mean bonus pay.

2.4. **Mean** GPG in hourly pay is 18.95% which is a 5.07% decrease from our 2022-2023 data, a significant improvement that is continuing to move in the right direction. Nearly all NHS organisations have a GPG in favour of men. The reasons for this are explained below.

2.5. **Median** GPG in hourly pay is 1.43% in favour of women. This is a 9.08% increase from our 2022-2023 data, which again is moving in the right direction, year on year since 2020. This is a more significant shift compared to previous years and is due to an increase in the median hourly rate for females. Median rate for males remained almost the same between year.



Mandatory Reporting Area	Data for 2019-20	Data for 2020-21	Data for 2021-22	Data for 2022-23	Data for 2023-2024
Mean gender pay gap in hourly pay	30.24%	28.20%	27.39%	24.02%	18.95%
Median gender pay gap in hourly pay	14.19%	11.19%	10.63%	7.65%	-1.43%
Mean bonus gender pay gap	16.19%	20.46%	21.61%	5.21%	1.92%
Median bonus gender pay gap	66.67%	37.78%	66.67%	34.58%	48.46%

Proportion of males & females within the whole workforce receiving a bonus payment	Males (%)		Females (%)		Males (%)		Females (%)		Males (%)		Females (%)		Males (%)		Females (%)		Males (%)		Females (%)	
	52	6.44%	15	0.52%	51	5.76%	14	0.47%	50	5.33%	13	0.42%	44	4.43%	12	0.38%	39	3.40%	12	0.35%

2.6. All DCH staff, except for medical staff, and executive managers (VSM) are paid on the National Agenda for Change (AfC) pay, terms and conditions of service. The terms and conditions set out band structures and pay for all employees to ensure transparency, fairness and equal treatment for all. The table below details the number and percentage of female and male staff within each pay band. All the pay bands, except for the Board, Medical and Band 9 are representative of the organisations gender ratio showing more female staff than male across each band.

2.7. It shows we have a median gender pay gap in favour of males in Ad Hoc salaries, Bands 2, 3, 5, 8a, 8c, 8d and medical staff. However, an improvement in women in more senior roles with a median gender pay gap in favour of females in Bands 8a and 9 with a neutral position for Bands 7 and 8b neither favouring male or female employees.

Gender Profile by Pay Band (based on the median pay of that band)

	Female		Male		Total	
Grouped Pay Scale	**Headcount**	**%**	**Headcount**	**%**	**Headcount**	**Median Pay Gap**
Ad Hoc*	1	25.00	3	75.00	4	**20.74%**
Apprentice	57	77.03	17	22.97	74	**-22.56%**
Band 1	11	91.67	1	8.33	12	**-10.06%**
Band 2	469	64.51	258	35.49	727	**1.53%**
Band 3	509	80.67	122	19.33	631	**1.24%**
Band 4	235	79.39	61	20.61	296	**-2.32%**
Band 5	551	85.83	91	14.17	642	**1.15%**
Band 6	476	84.40	88	15.60	564	**-0.94%**
Band 7	299	83.29	60	16.71	359	**0.00%**
Band 8a	85	71.43	34	28.57	119	**2.67%**
Band 8b	31	73.81	11	26.19	42	**0.00%**
Band 8c	13	65.00	7	35.00	20	**10.91%**
Band 8d	1	33.33	2	66.67	3	**31.06%**
Band 9	4	40.00	6	60.00	10	**3.85%**
Medical*	197	44.37	247	55.63	444	**20.26%**
Board*	0	0.00	3	100.00	3	**-**
Grand Total	**2939**	**74.41**	**1011**	**25.59**	**3950**	

**indicates sits outside Agenda for Change*
- indicates positive for females

2.8. The DCH GPG of -1.43% means we are significantly lower than the national average of 7% for full time employees, (Source: Gender Pay Gap in the UK: Office for National Statistics, April 2024) it is worth remembering that the gender pay gap is not the same

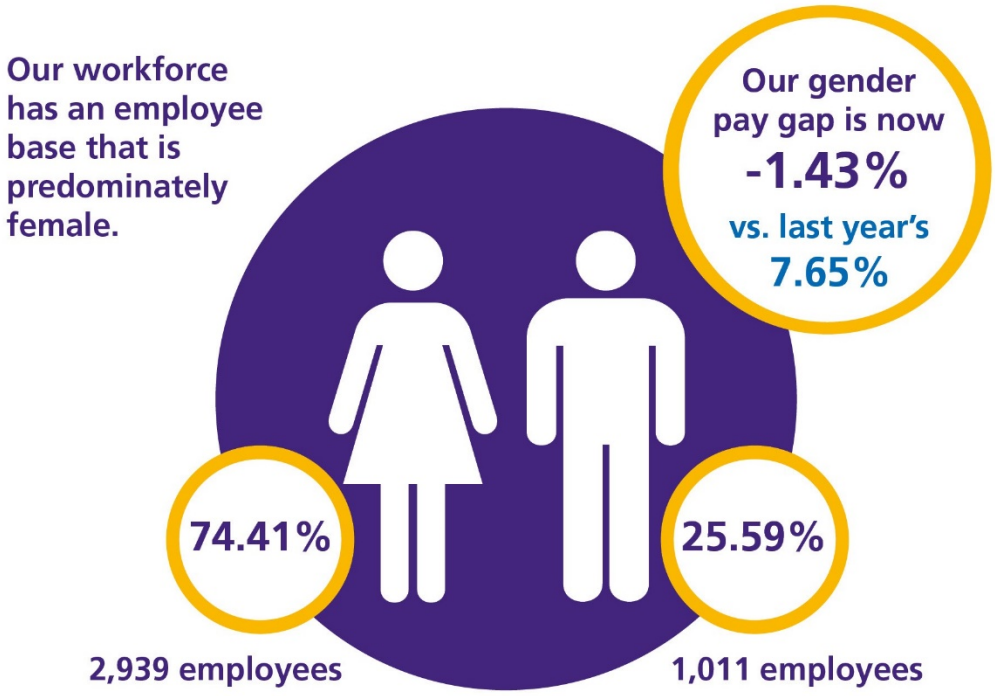
as unequal pay. This can be simplified by understanding that we have more men than women in higher paid roles.

2.9. While men make up only 25.59% of the DCH workforce, there is a disproportionate number of males in the higher paid roles, namely 34.1% of those are in roles band 8a and above. Showing men remain more highly represented in higher paid roles. Significant improvement between years indicates women are becoming more represented in the higher quartiles.

3. Conclusion

3.1 The causes of the gender pay gap can be complex and overlapping. Even though we have seen a significant decrease to -1.43% from a high of 14.19% in 2020 the gap remains due to:

- An overall increase in the workforce in the last three years
- Roles in the lower quartiles, specifically, Bands 1-7 are predominantly staffed by females.
- As a percentage there are more males in higher paid jobs (Band 8d and above) than lower paid jobs. Despite a significant improvement in the number of females in senior roles at DCH, as a percentage more females remain in lower paid jobs than in higher paid jobs.
- A higher proportion of women choose occupations that offer less financial reward for example, in administration, catering and domestics. Many high-paying sectors are disproportionately made up of male workers, for example, medical, finance or digital information technology.
- Being a female dominated organisation, more of our female staff may be subject to the 'motherhood gap.' A much higher proportion of women work part-time, and part-time workers earn less than their full-time counterparts on average.
- In general, according to the national landscape women are still less likely to progress up the career ladder into high-paying senior roles. Although we have seen an increase year on year in the percentage of females in Band 8a, 8b, 8c, and medical levels there remains a significantly fewer females in bands 8d, 9 and Board level.
- At DCH, whilst we have a higher proportion of female staff in our workforce, we also have a significant proportion of our male workforce now at the point in their careers where they are senior medical staff and therefore are higher up the pay grades than some more junior members of staff. This is reflected in the GPG amongst our medical staff. With an increasing number of females choosing to pursue medicine and other previously male-dominated roles as a career we can see gradual improvements in the GPG.



4. Addressing our Gender Pay Gap / Recommendations

4.1 Ongoing actions to continue our improvement journey in relation to our GPG include:

- Continued commitment to support workplace flexibility, encouraging managers to advocate flexible working.
- Promote flexible working options as part of advertising new roles to improve recruitment and retention.
- Improve the composition of diverse selection panels.
- Promote all opportunities across the workforce with a focus on those colleagues covered by a protected characteristic including females.
- Ongoing analysis into why a gap still exists with some specific focus on differences between pay-band and un-banded staff to influence change.
- In addition to our current Staff Networks offer networking and peer support for females in the workplace.
- Support the development of female employees through mentoring and leadership development. Give focus to our female employees in the lower bands to equip them with the skills and to give them the confidence to apply for our more senior posts.
- Whilst we have commenced our work with local communities to build a sustainable and representative workforce, we could continue to do so giving access and increased opportunity to vacancies at DCH.

- Ensuring the Trust is aligned with the principles of the NHS People Plan which will contribute to our goal to be recognised as an employer of choice and a place to develop a long term clinical and non-clinical career.

To conclude, a positive improvement in our GPG has continued for 4 consecutive years to reach -1.43% as of 31st March 2024. The introduction of an Inclusion & Belonging Strategy will enable us to continually review and hopefully make further improvements to close the gap even further.

5. Recommendations

The Board is recommended to:
Receive the report for **assurance**

Name of Author: **Melanie Harris**
Title of Author: **HR Manager**
Date **28 January 2025**

6. Appendices

6.1 Appendix A – DCH GPG summary infographic

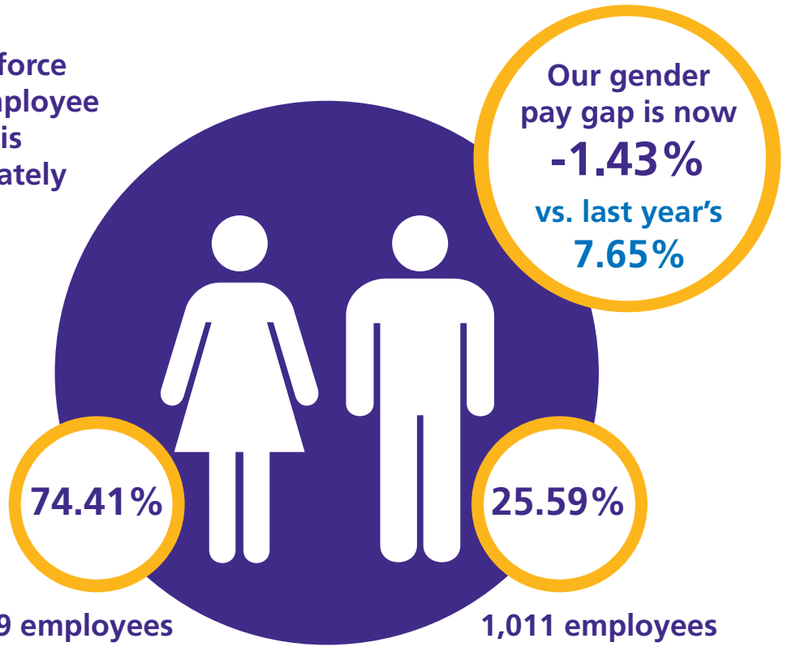
Figures taken as of 31 March 2024 – including Bank staff

Dorset County Hospital
NHS Foundation Trust

Story of our gender pay gap

We fully support the equality of opportunity and continue to progress actions in order to close the gap and achieve this. We have seen improvements year on year since 2020. This year has seen our most significant decrease of 9.08% and for the first time we have found the pay gap to be in favour of women. The number of female staff represented in senior positions has increase. The improvement in our gender pay gap is attributed to the improvement in the median hourly rate for female staff from £15.91 in 2023 to £17.53 in 2024. The median hourly rate for males did also increase but not as significantly.

Our workforce has an employee base that is predominately female.

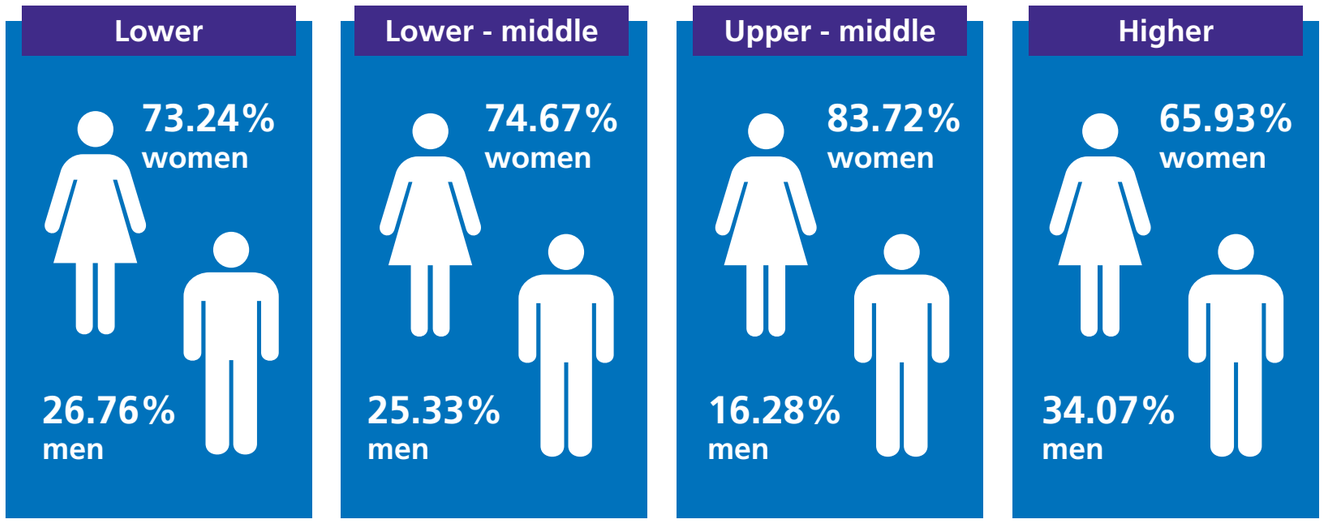


Moving forward

We will continue to progress our actions to maintain the improvements made so far. Our actions will include:

1. Continued commitment to support workplace flexibility, encouraging managers to advocate flexible working.
2. Promote all opportunities across the workforce with a focus on those colleagues covered by a protected characteristic including females.
3. In addition to our current staff networks offer networking and peer support for females in the workplace.
4. Support the development of female employees through mentoring and leadership development. Give focus to our female employees in the lower bands to equip them with the skills and to give them the confidence to apply for our more senior posts.
5. Ensuring the Trust is aligned with the principles of the NHS People Plan which will contribute to our goal to be recognised as an employer of choice and a place to develop a long term clinical and non-clinical career.
6. Ongoing analysis into why a gap still exists in some pay bands to continue to influence change.

Proportion of males and females in each pay quartile



Median gender pay gap (in hourly pay)

Median female hourly salary £17.53

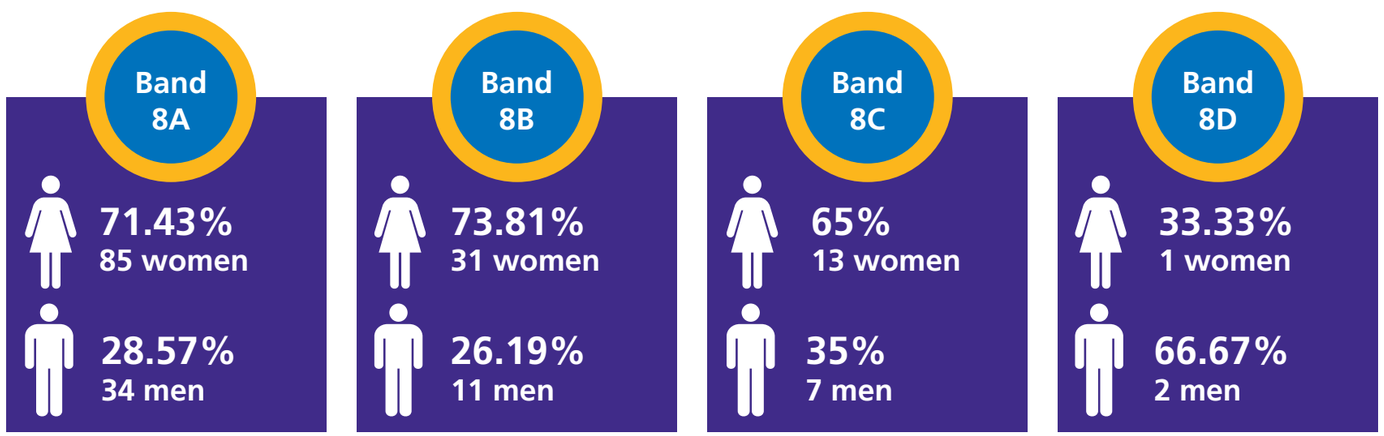
Median male hourly salary £17.28

Mean gender pay gap (in hourly pay)

Mean female hourly salary £19.05

Mean male hourly salary £23.89

Senior agenda for change grades



Report to	DCH Board of Directors	
Date of Meeting	8th April 2025	
Report Title	**2024 NHS Staff Survey Results – Dorset County Hospital**	
Prepared By	Julie Barber – Head of Organisational Development	
Approved by Accountable Executive	Nicola Plumb – Joint Chief People Officer	
Previously Considered By	Senior Leadership Group (SLG) - 20th March 2025 People and Culture Committee in Common - 24th March 2025	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	**Yes**	
Colleagues	**Yes**	
Communities	**Yes**	
Sustainability	**Yes**	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	This paper relates to both current BAF workforce risks as it links to engagement, belonging and retention. SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care. SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	
Financial	The financial implication for the staff survey is the ongoing budgetary requirement to pay for the provider to facilitate the survey and provide us with the results. This year's cost was £12,161.92 including VAT plus the additional incentive costs of £433 including VAT.	
Statutory & Regulatory	Participation in the annual NHS Staff Survey is a mandatory requirement for all NHS Trusts nationally.	
Equality, Diversity & Inclusion	The results provide us with specific data in relation to Equality, Diversity & Inclusion and also inform our other statutory reports linked to Workforce Race Equality Standards and Workforce Disability Equality Standards. Additional questions also link to our commitments to the NHS National Sexual Safety Charter.	
Co-production & Partnership	Each NHS Trust has to pay for its own provision to the organisation that delivers the staff survey and although both DHC and DCH use the same provider, the contracts remain distinct and are managed independently. The data for each Trust is specific and the benchmarking groups they are assessed against are also different.	

Executive Summary

The purpose of the paper is to provide a high-level summary of the 2024 NHS Staff Survey results. The full results are also shared. A response rate of 46.4% was achieved (1,747 employees). This is an improvement of 5.4% from last year. The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 49%.
Out of the 7 People Promise elements, 5 have improved and 2 have declined (although none of the differences in scores are statistically significant). 5 of the People Promise elements are significantly better than the sector average. Just one People Promise element (We are safe and healthy) scored lower than average (by 0.04%) with declining scores relating to work pressures.

The Employee Engagement index continues to have a score out of 10. Our score has declined since last year from 7.07 to 7.03 but is not considered statistically significant. A score of 7.0 or more is considered excellent. The DCH Staff Engagement score is significantly better than the sector average. The theme of Morale has declined since last year from 6.0 to 5.9 but is not considered statistically significant.

Drilling down further, there are some encouraging results in relation to flexible working, line management and reasonable adjustments for disabled staff, reflecting our focus in these areas over the past 18 months. It is also great to see an overall increase in those recommending the Trust as a place to work (67.6%).

We continue to utilise the results to identify positive outcomes, areas to improve and any trends worthy of note. At a local level, divisional and team leaders will be cascading results using a newly created NSS Results Toolkit and Action Plan template to encourage consistent approaches.

An overview of the People Promise elements and themes is shown at **Appendix A.**

Recommendation

The Board are requested to:

- Receive the report for **assurance**

2024 National NHS Staff Survey Results

Executive Summary

The purpose of the paper is to provide a high-level summary of the 2024 NHS Staff Survey results, to showcase both positive and negative trajectories and to highlight work ongoing within the Trust which will impact on areas explored within the Survey.

The 2024 NHS Staff Survey was conducted between October and December last year. A response rate of 46.4% was achieved (1,747 employees). This is an improvement of 5.4% from last year. The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 49%.

A response rate of 40% or more is considered good and provides an accurate indication of what our staff are thinking. It also means we can consider statistical significance and make robust conclusions about the data.

Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale).

Out of the 7 People Promise elements, 5 have improved and 2 have declined (although none of the differences in scores are statistically significant). 5 of the People Promise elements are significantly better than the sector average. Just one People Promise element (We are safe and healthy) scored lower than average (by 0.04%) due to declining scores relating to work pressures. An overview of the People Promise elements and themes is shown at **Appendix A.**

The Employee Engagement index continues to have a score out of 10. Our score has declined since last year from 7.07 to 7.03 but is not considered statistically significant. A score of 7.0 or more is considered excellent. The DCH Staff Engagement score is significantly better than the sector average.

The theme of Morale has declined since last year from 6.0 to 5.9 but is not considered statistically significant.

Drilling down further, there are some encouraging results in relation to flexible working, line management and reasonable adjustments for disabled staff, reflecting our focus in these areas over the past 18 months. It is also great to see an overall increase in those recommending the Trust as a place to work (67.6%).

We continue to utilise the results to identify positive outcomes, areas to improve and any trends worthy of note. At a local level, divisional and team leaders will be cascading results using a newly created NSS Results Toolkit and Action Plan template to encourage consistent approaches.

Deeper dives into team results will be aided by the implementation of the TED Team Support Tool, which following a 'soft launch' in April will be more widely implemented by early summer.

Our programmes of work are being reviewed considering staff survey and People Pulse results alongside local intelligence collaborations which will help drive improvements to our staff development offers and targeted support initiatives.

This paper follows the publication of the results on 13th March 2025 and serves as a supplement to the detailed survey report.

1. Introduction

The 2024 NHS Staff Survey was conducted between October and December last year. A response rate of 46.4% was achieved (1,747 employees) which was an increase of 5.4% from 2023. The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 49%. Given this response rate, it is important that the survey results are used alongside all other sources of staff feedback including the quarterly People Pulse results, freedom to speak up data, local intelligence meetings and the experiences of staff collated via departmental visits. Each year we utilise the results to identify positive outcomes, areas to improve any trends worthy of note.

2. Overview of Survey Results

2.1 Overview of People Promise elements and themes

Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale).

Out of the 7 People Promise elements, 5 have improved and 2 have declined (although none of the differences in scores are statistically significant). 5 of the People Promise elements are significantly better than the sector average. Just one People Promise element (We are safe and healthy) scored lower than average (by 0.04%). An overview of the People Promise elements and themes is shown at **Appendix A.**

The two themes of Staff Engagement and Morale have reduced slightly.

The Employee Engagement index continues to have a score out of 10. Following a decline in scores in 2021 & 2022, our 2023 score rose to 7.07 but has slightly declined for 2024 to 7.03. A growing body of evidence links staff engagement to patient outcomes.

The theme of Morale increased last year to 6.00, but has slightly declined this year to 5.93, which is not considered statistically significant.

2.2 Staff Engagement/Employee Engagement Index (EEI) score

Whilst there has been a slight decrease in the overall staff engagement score this year, from 7.07 to **7.03,** our survey provider continues to point out that a score of 7 or over is excellent.

The staff engagement score is calculated from the scores of 9 questions relating to 3 themes (sub scores): motivation, involvement and advocacy. The theme of **advocacy** is considered particularly important as it is scrutinised by the CQC in terms of 'friends and family' test question (25d) 'if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' which shows a significant decline (3.5%) although remains significantly better than the sector average. Our score for recommending the Trust as a place to work has improved and is significantly better than the sector average.

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
Theme - Staff engagement	7.07	Not Significant	7.03	Significantly Better	6.85
Subscore 1 - Motivation	7.08	Not Significant	7.06	Significantly Better	6.94
2a. I look forward to going to work.	57.5%	Not Significant	57.3%	Significantly Better	53.4%
2b. I am enthusiastic about my job.	72.5%	Not Significant	70.8%	Significantly Better	67.0%
2c. Time passes quickly when I am working.	72.8%	Not Significant	73.0%	Significantly Better	70.1%
Subscore 2 - Involvement	7.07	Not Significant	7.05	Significantly Better	6.81
3c. There are frequent opportunities for me to show initiative in my role.	79.9%	Not Significant	77.1%	Significantly Better	72.9%
3d. I am able to make suggestions to improve the work of my team / department.	74.4%	Not Significant	75.6%	Significantly Better	70.4%
3f. I am able to make improvements happen in my area of work.	60.7%	Not Significant	60.4%	Significantly Better	55.7%
Subscore 3 - Advocacy	7.05	Not Significant	6.99	Significantly Better	6.80
25a. Care of patients / service users is my organisation's top priority.	77.8%	Not Significant	76.1%	Not Significant	75.1%
25c. I would recommend my organisation as a place to work.	66.5%	Not Significant	67.6%	Significantly Better	61.3%
25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	71.8%	Significantly Declined	68.2%	Significantly Better	64.9%

2.2.1 Staff Engagement trajectory 2015-2024

Year	Dorset County Hospital	Best within benchmark group	Average within benchmark group
2015	7.0	7.6	7.0
2016	7.0	7.4	7.0
2017	7.1	7.4	7.0
2018	7.2	7.6	7.0
2019	7.2	7.6	7.0
2020	7.2	7.6	7.0
2021	7.1	7.4	6.8
2022	7.0	7.3	6.8
2023	7.1	7.3	6.9
2024	7.0	7.4	6.8

Our Staff Engagement scores over the last 10 years have fluctuated between 7.0 and 7.2, and we have reduced from last year to 7.0, but this is significantly better than the sector average.

2.3 Morale

There has been a slight decrease in the overall score for morale this year, to 5.93, which is not statistically significant. Our survey provider pointed out that a score of over 6 is excellent, so we have just slipped below this. Morale is broken down into 3 themes (sub scores), with 13 questions evidencing the areas of: thinking about leaving, work pressure and stressors. **Work pressures are largely responsible for the decline in this year's score.**

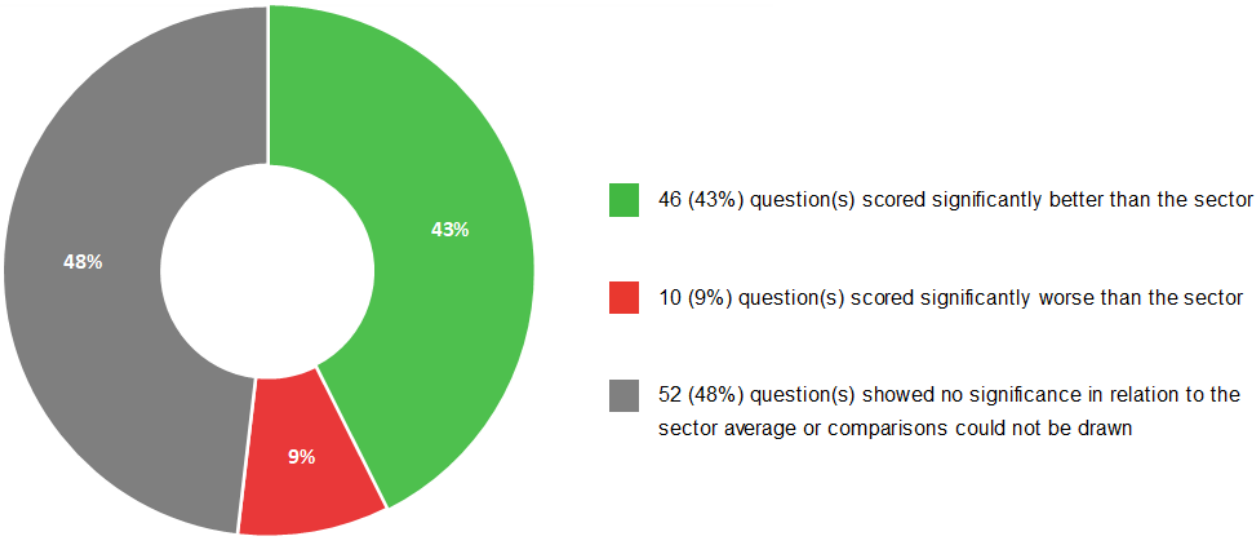
Question 26c indicate a group of our most disengaged staff who state they will leave the organisation as soon as they can find another job. This score is high across the NHS at 16.2%, and our score is significantly better than that.

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
Theme - Morale	6.00	Not Significant	5.93	Not Significant	5.93
Subscore 1 - Thinking about leaving	6.29	Not Significant	6.28	Significantly Better	6.06
26a. I often think about leaving this organisation.	28.0%	Not Significant	27.1%	Not Significant	28.2%
26b. I will probably look for a job at a new organisation in the next 12 months.	18.0%	Not Significant	20.2%	Not Significant	20.9%
26c. As soon as I can find another job, I will leave this organisation.	13.0%	Not Significant	13.7%	Significantly Better	16.2%
Subscore 2 - Work pressure	5.25	Significantly Declined	5.08	Significantly Worse	5.36
3g. I am able to meet all the conflicting demands on my time at work.	44.3%	Significantly Declined	40.3%	Significantly Worse	47.6%
3h. I have adequate materials, supplies and equipment to do my work.	57.0%	Significantly Declined	53.0%	Significantly Worse	56.3%
3i. There are enough staff at this organisation for me to do my job properly.	29.6%	Not Significant	29.5%	Significantly Worse	33.3%
Subscore 3 - Stressors	6.47	Not Significant	6.44	Not Significant	6.39
3a. I always know what my work responsibilities are.	86.4%	Not Significant	85.6%	Not Significant	86.7%
3e. I am involved in deciding on changes introduced that affect my work area / team / department.	56.5%	Not Significant	55.1%	Significantly Better	50.5%
5a. I have unrealistic time pressures.	23.7%	Not Significant	24.5%	Not Significant	25.8%
5b. I have a choice in deciding how to do my work.	56.6%	Not Significant	55.2%	Significantly Better	51.6%
5c. Relationships at work are strained.	46.3%	Not Significant	45.8%	Not Significant	46.0%
7c. I receive the respect I deserve from my colleagues at work.	69.6%	Not Significant	70.5%	Not Significant	70.8%
9a. My immediate manager encourages me at work.	72.6%	Significantly Improved	76.4%	Significantly Better	71.5%

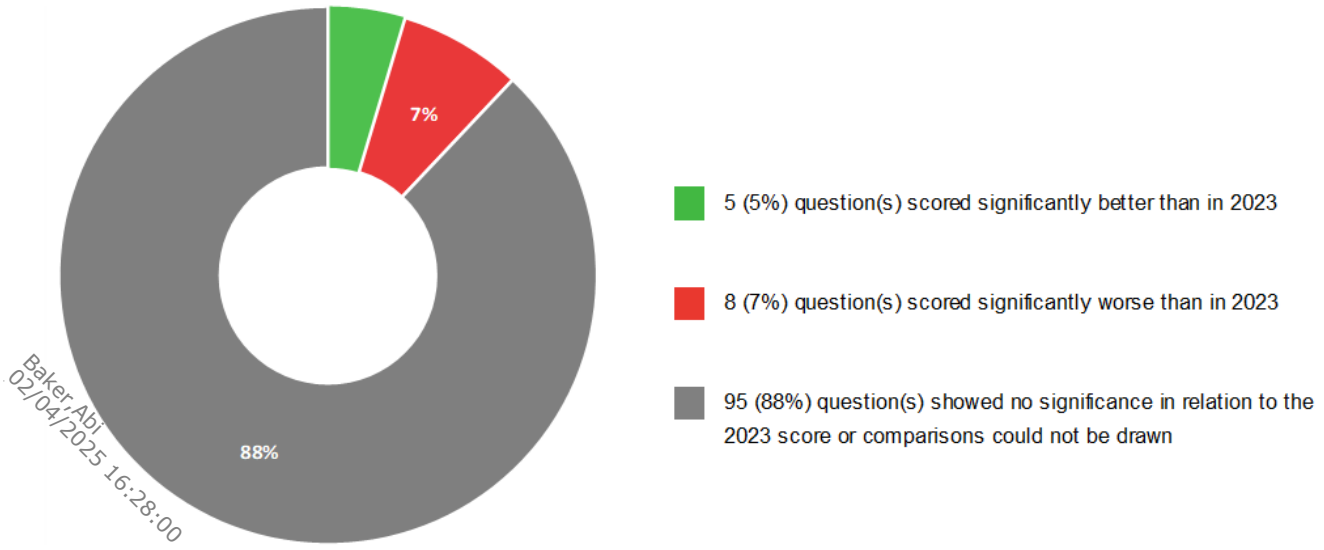
3. People Promise elements and sub-scores

Out of the 7 People Promise elements, 5 have improved and 2 have declined (although none of the differences in scores are statistically significant). 5 of the People Promise elements are significantly better than the sector average.

3.1 Headline findings – benchmarking:



3.2 Headline findings – changes since 2023:



3.3 Summary of scores:

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 1 - We are compassionate and inclusive	7.38	Not Significant	7.41	Significantly Better	7.22
People Promise 2 - We are recognised and rewarded	6.05	Not Significant	6.09	Significantly Better	5.90
People Promise 3 - We each have a voice that counts	6.83	Not Significant	6.81	Significantly Better	6.68
People Promise 4 - We are safe and healthy	6.14	Not Significant	6.05	Not Significant	6.09
People Promise 5 - We are always learning	5.65	Not Significant	5.75	Not Significant	5.69
People Promise 6 - We work flexibly	6.39	Not Significant	6.47	Significantly Better	6.22
People Promise 7 - We are a team	6.85	Not Significant	6.91	Significantly Better	6.74

A summary of the sub-scores is shown at **Appendix A**.

Three new questions were introduced last year within the element of 'We are safe and healthy', but do not contribute to sub-scores. However, we now have two years of data and can compare scores with last year's results:

Question	2023	2024	Sector average (2024)
Q17a: In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public	**7.40 %**	**7.96 %**	**7.98 %**
Q17b: In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues	**4.54 %**	**4.16 %**	**3.53 %**
Q22: I can eat nutritious and affordable food while I am working	**59.20 %**	**60.76 %**	**53.73 %**

We are well above the sector average for Q22 and this is likely to relate to our on-site restaurant which offers a variety of healthy food. There has been a decline in staff experiencing unwanted behaviour of a sexual nature from colleagues, although our score remains above the sector average. As part of our commitment to the Sexual Safety Charter we are continuing to tackle unwanted behaviour of a sexual nature and will shortly be implementing a dedicated policy and reporting system. NHS England online training on sexual misconduct is now mandatory for all staff.

4. Questions not linked to People Promise elements or themes

Question 16c interrogates discrimination on grounds of the protected characteristics.

Question	Category	Scores
16c1	Ethnic background	53.08% - significant rise from last year (34.64%) but is **lower** than Benchmark – 56.16%
16c2	Gender	20.75% - reduced from last year but is **higher** than Benchmark – 18.49%
16c3	Religion	2.48% - slightly reduced from last year and is significantly **lower** than Benchmark 4.81%
16c4	Sexual orientation	3.09% - a rise from last year but **lower** than Benchmark 3.67%
16c5	Disability	4.40% – a very significant drop from last year and **much lower** than Benchmark 9.12%
16c6	Age	14.46% - a drop from last year and **lower** than Benchmark 16.15%
16c7	Other	25.92% - a drop from last year but **higher** than Benchmark 21.99% A*s this category sits outside the protected characteristics, we will need to investigate further to find out what is behind this statistic.*

The breakdown for Q.16 (apart from c7 mentioned above) cites levels of discriminatory behaviour relating to the protected characteristics covered by the Equality Act 2010. Our EDIB Workplan includes initiatives to target discrimination in all its forms and advocates zero tolerance.

We have worked hard to raise awareness about discrimination through our programmes of work such as Dignity & Respect at Work, Conscious Inclusion and Inclusive Leadership. The increased rise in reports of discrimination on grounds of ethnicity could be evidence of staff recognising discriminatory behaviours more effectively. There is still a lot of work to be done in this area.

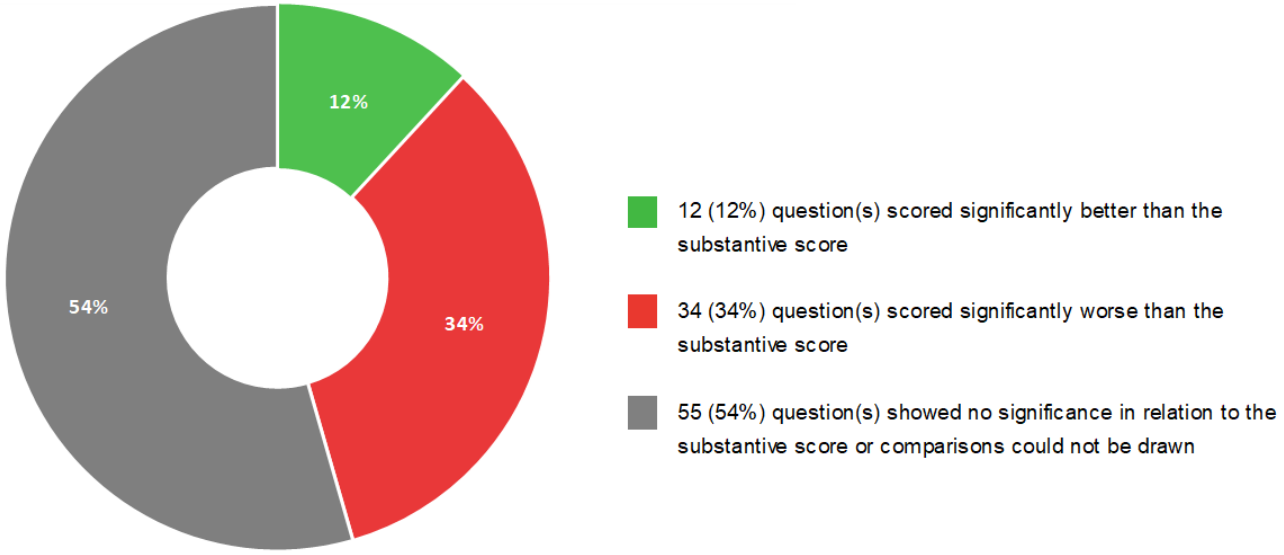
5. Bank Workers

738 surveys were sent to Bank Workers which yielded 202 responses, so a response rate of 27.4%.

5.1 **Summary of scores for Bank workers**:

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sub. Score
Theme - Staff engagement	6.88	Not Significant	6.64	Significantly Worse	7.01
Theme - Morale	5.77	Not Significant	5.66	Significantly Worse	5.93
People Promise 1 - We are compassionate and inclusive	7.24	Not Significant	7.14	Significantly Worse	7.41
People Promise 2 - We are recognised and rewarded	5.98	Not Significant	6.07	Not Significant	6.10
People Promise 3 - We each have a voice that counts	6.38	Not Significant	6.26	Significantly Worse	6.80
People Promise 4 - We are safe and healthy	6.72	Not Significant	6.66	Significantly Better	6.07
People Promise 5 - We are always learning	6.11	Not Significant	5.99	Not Significant	5.71
People Promise 6 - We work flexibly	6.55	Not Significant	6.45	Not Significant	6.49
People Promise 7 - We are a team	6.57	Not Significant	6.50	Significantly Worse	6.91

5.2 Comparison to substantive staff (headline findings):



5.3 Key differences

- Over half of the People Promise scores for bank workers are worse than the Trust's substantive scores. 'We are safe and healthy' is significantly better than the substantive score, whereas Staff Engagement and Morale scores, 'We are compassionate and inclusive', 'We each have a voice that counts', and 'We are a team' are worse.
- Bank workers report less positively to questions about immediate managers, and appraisals and are less likely to feel involved in the workplace, in particular with proposed changes which affect them. This is likely to be due to the transient nature of their work.

- Bank workers report less positively to development opportunities. They report less positively when it comes to the autonomy and control they have at work, they feel less likely to be able to make changes and improvements at work. They also report less positively regarding fairness towards staff involved in an error, near miss, or incident.

5.4 Recommendations

We need to promote a culture in which bank workers feel their opinions and skills are welcomed, sought-after and valued, and that they are given opportunities to show initiative in their role.

Bank workers will be fully included in the analysis process when results are disseminated to divisions and teams. The disparities will be owned and investigated at local level with oversight from the Bank Engagement Lead, so any learning can be shared.

6. WRES

The current full WRES report, published on our website, uses Staff Survey figures from the 2023 Staff Survey. The 2024 figures provide an early indication of declines and improvements in the 4 questions that form part of the WRES. In comparison with the 2023 scores, there are improvements for BME staff in half of the questions whereas white staff have reported improvements in all 4.

Cases of harassment, bullying, abuse and discrimination are all unacceptably high for all colleagues and will continue to be an area of focus. It is however encouraging that harassment, bullying or abuse from staff has been on a declining trajectory for the past three years.

Our Dignity and Respect at Work Programme continues to educate and support staff to challenge unacceptable behaviour and call out bullying and harassment in all its forms.

Question – WRES data DCH	BME 2024	BME 2023	BME 2022	WHITE 2024	WHITE 2023	WHITE 2022
% of staff experiencing harassment, bullying or abuse from **patients or relatives** in last 12 months	**25.08**	**22.01**	**29.76**	**20.18**	**18.01**	**25.04**
% of staff experiencing harassment, bullying or abuse from **staff** in last 12 months	**24.16**	**25.84**	**32.35**	**21.40**	**22.57**	**24.94**
% of staff who feel the organisation provides equal opportunities for career progression or promotion	**55.73**	**59.31**	**47.02**	**60.20**	**58.09**	**60.74**
% of staff who experienced discrimination at work from manager/team leader or colleague in last 12 months	**17.85**	**17.96**	**16.57**	**5.42**	**7.76**	**6.13**

7. Workforce Disability Equality Standard (WDES)

Disabled staff show improvements in 5 questions and declines in 4 (9 questions in total). For the 8 questions relevant to non-disabled staff, there are improvements in 4 and declines in 4.

It is disappointing to see less reporting of incidents (both staff groups) as this reduces our ability to identify where action needs to be targeted.

There is good news regarding the positive trajectory of disabled staff reporting reasonable adjustments and that both staff groups are experiencing reduced pressure from their managers to come into work when they are unwell. These improvements may be linked to the focus we have had on reasonable adjustments and manager training. The Without Limits Staff Network has been intrinsic in strengthening the policy, training and processes relating to reasonable adjustments.

Question – WDES data DCH	Disabled 2024	Disabled 2023	Disabled 2022	Non-Disabled 2024	Non-Disabled 2023	Non-Disabled 2022
% of staff experiencing harassment, bullying or abuse from **patients or relatives** in last 12 months	**28.41**	**22.77**	**28.77**	**18.29**	**17.11**	**24.51**
% of staff experiencing harassment, bullying or abuse from **managers** in last 12 months	**13.72**	**14.51**	**15.97**	**6.95**	**7.53**	**9.90**
% of staff experiencing harassment, bullying or abuse from **other colleagues** in last 12 months	**24.45**	**24.21**	**28.81**	**15.61**	**18.04**	**18.90**
% of staff who reported last experience of harassment, bullying or abuse	**47.24**	**53.57**	**52.00**	**47.15**	**51.57**	**42.77**
% of staff who feel the organisation provides equal opportunities for career progression or promotion	**54.19**	**55.26**	**59.10**	**60.55**	**59.34**	**58.59**
% of staff who felt pressure from their manager to come into work when not feeling well enough	**18.18**	**24.51**	**28.63**	**15.92**	**18.00**	**18.11**
% of staff who are satisfied with the extent the organisation values their work	**37.28**	**36.81**	**36.49**	**48.02**	**48.42**	**46.43**
% of staff who say their employer has made reasonable adjustments to enable them to carry out their work	**77.82**	**70.33**	**71.92**	**N/A**	**N/A**	**N/A**

Staff Engagement Score	**7.01**	**6.71**	**6.59**	**6.71**	**7.19**	**7.06**

8. Approach to acting on results

8.1 There is more work to do in analysing and understanding what the results of the survey are telling us. There are some disparities between different service areas and these will need to be unpicked at a local level, in line with the expectation that survey results are owned in teams and services.

8.2 There are clearly some areas of concern where scores on individual questions have significantly declined. Areas to focus on include appraisal coverage, reviewing reports of errors/near misses/incidents and looking deeper into work demands.

8.3 DCH will be implementing the TED Team Support Tool during April and May to support team development. The tool is aligned to the People Promise elements and will help with deeper dives into Staff Survey results at team level.

8.4 Once the qualitative feedback is available (April), it will be triangulated through our local intelligence processes to illustrate more fully what this means for DCH.

9. Conclusion

9.1 The full staff survey report was made available online on 13th March 2025 at www.nhsstaffsurveys.com. This paper sought to provide a headline analysis of Dorset County Hospital's results.

9.2 The results give us the opportunity to respond to the needs of our staff. Combined with the insights we have from other sources, they put us in a positive position to continue our work to improve staff experience.

9.3 None of the differences in scores are statistically significant across all the People Promise elements and the two themes. 5 of the People Promise elements are significantly better than the sector average. Just one People Promise element (We are safe and healthy) scored lower than average (by 0.04%). The theme of Engagement is significantly better than the sector average.

9.4 Improvements or declines in scores are mostly relatively small but they still allow us to identify areas of good practice and areas for improvement. It is encouraging to see an improvement in results relating to flexible working, line management and reasonable adjustments for disabled staff, as there has been significant focus in these areas over the past 18 months.

9.5 We will now use these results to continue our honest dialogue with all colleagues to understand their lived experience, assess what more we can do to support staff and work together to improve our working lives.

10. Recommendation

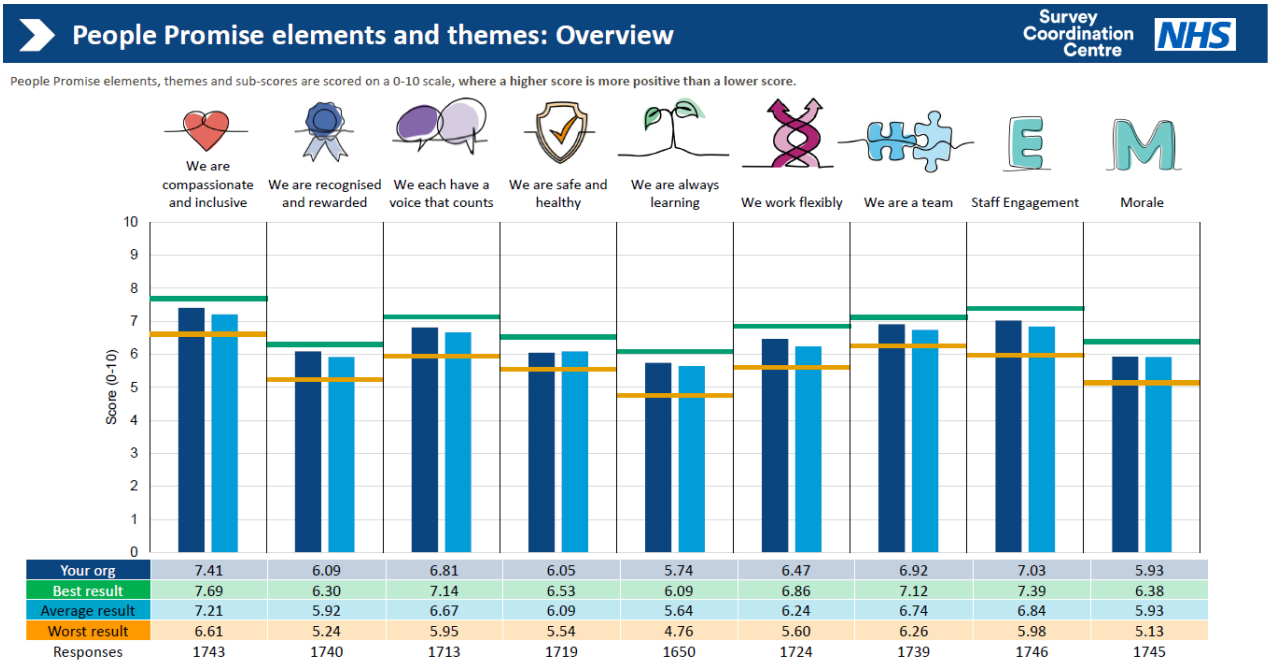
The Board are requested to receive the report for assurance.

Name and Title of Author: Julie Barber, Head of Organisational Development

Appendix A: Summary of People Promise elements and sub-scores

APPENDIX A

People Promise Overview and Subscores Summary



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.41	6.09	6.81	6.05	5.74	6.47	6.92	7.03	5.93
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	1743	1740	1713	1719	1650	1724	1739	1746	1745

(1) We are compassionate and inclusive

People Promise/Theme/Question		2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 1 - We are compassionate and inclusive		7.38	Not Significant	7.41	Significantly Better	7.22
People Promise 1, Subscore 1 - Compassionate culture		7.24	Not Significant	7.19	Significantly Better	7.11
6a.	I feel that my role makes a difference to patients / service users.	88.2%	Not Significant	86.3%	Significantly Worse	88.1%
25a.	Care of patients / service users is my organisation's top priority.	77.8%	Not Significant	76.1%	Not Significant	75.1%
25b.	My organisation acts on concerns raised by patients / service users.	70.2%	Not Significant	71.8%	Not Significant	71.0%
25c.	I would recommend my organisation as a place to work.	66.5%	Not Significant	67.6%	Significantly Better	61.3%
25d.	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	71.8%	Significantly Declined	68.2%	Significantly Better	64.9%
People Promise 1, Subscore 2 - Compassionate leadership		7.13	Not Significant	7.29	Significantly Better	6.97
9f.	My immediate manager works together with me to come to an understanding of problems.	71.1%	Not Significant	73.9%	Significantly Better	68.4%
9g.	My immediate manager is interested in listening to me when I describe challenges I face.	73.7%	Not Significant	75.7%	Significantly Better	71.1%
9h.	My immediate manager cares about my concerns.	72.5%	Not Significant	74.7%	Significantly Better	69.6%
9i.	My immediate manager takes effective action to help me with any problems I face.	67.9%	Not Significant	69.3%	Significantly Better	66.6%

People Promise 1, Subscore 3 - Diversity and equality		8.21	Not Significant	8.26	Significantly Better	8.01
15.	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	58.3%	Not Significant	59.2%	Significantly Better	54.5%
16a.	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	6.3%	Not Significant	7.2%	Significantly Better	10.0%
16b.	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	9.7%	Not Significant	8.4%	Significantly Better	9.9%
21.	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	73.0%	Not Significant	74.2%	Significantly Better	69.8%

Additional – discrimination

Question		2023 Score	Significance	2024 Score	Significance	Sector Score
16c01.	On what grounds have you experienced discrimination? Ethnic background	35.6%	Significantly Declined	54.4%	Not Significant	59.9%
16c02.	On what grounds have you experienced discrimination? Gender	21.9%	Not Significant	21.3%	Not Significant	18.7%
16c03.	On what grounds have you experienced discrimination? Religion	2.5%	Not Significant	2.6%	Significantly Better	6.7%
16c04.	On what grounds have you experienced discrimination? Sexual orientation	1.2%	Not Significant	3.2%	Not Significant	4.0%
16c05.	On what grounds have you experienced discrimination? Disability	11.6%	Significantly Improved	4.4%	Significantly Better	8.1%
16c06.	On what grounds have you experienced discrimination? Age	18.1%	Not Significant	14.7%	Not Significant	15.4%
16c07.	On what grounds have you experienced discrimination? Other	31.1%	Not Significant	24.2%	Not Significant	21.1%

(2) We are recognised and rewarded

People Promise/Theme/Question		2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 2 - We are recognised and rewarded		6.05	Not Significant	6.09	Significantly Better	5.90
4a.	The recognition I get for good work.	55.2%	Not Significant	55.4%	Significantly Better	52.7%
4b.	The extent to which my organisation values my work.	45.5%	Not Significant	45.0%	Not Significant	43.6%
4c.	My level of pay.	33.2%	Not Significant	33.5%	Significantly Better	30.4%
8d.	The people I work with show appreciation to one another.	68.2%	Not Significant	67.1%	Not Significant	66.1%
9e.	My immediate manager values my work.	73.5%	Not Significant	76.2%	Significantly Better	71.4%

(3) We each have a voice that counts

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 3 - We each have a voice that counts	6.83	Not Significant	6.81	Significantly Better	6.68
People Promise 3, Subscore 1 - Autonomy and control	7.13	Not Significant	7.08	Significantly Better	6.95
3a. I always know what my work responsibilities are.	86.4%	Not Significant	85.6%	Not Significant	86.7%
3b. I am trusted to do my job.	90.1%	Not Significant	90.2%	Not Significant	90.2%
3c. There are frequent opportunities for me to show initiative in my role.	79.9%	Not Significant	77.1%	Significantly Better	72.9%
3d. I am able to make suggestions to improve the work of my team / department.	74.4%	Not Significant	75.6%	Significantly Better	70.4%
3e. I am involved in deciding on changes introduced that affect my work area / team / department.	56.5%	Not Significant	55.1%	Significantly Better	50.5%
3f. I am able to make improvements happen in my area of work.	60.7%	Not Significant	60.4%	Significantly Better	55.7%
5b. I have a choice in deciding how to do my work.	56.6%	Not Significant	55.2%	Significantly Better	51.6%
People Promise 3, Subscore 2 - Raising concerns	6.53	Not Significant	6.55	Significantly Better	6.42
20a. I would feel secure raising concerns about unsafe clinical practice.	73.0%	Not Significant	74.1%	Significantly Better	70.7%
20b. I am confident that my organisation would address my concern.	58.0%	Not Significant	56.0%	Not Significant	56.4%
25e. I feel safe to speak up about anything that concerns me in this organisation.	65.1%	Not Significant	65.4%	Significantly Better	60.9%
25f. If I spoke up about something that concerned me I am confident my organisation would address my concern.	50.8%	Not Significant	52.0%	Significantly Better	49.0%

Additional – Errors, near misses or incidents

Question	2023 Score	Significance	2024 Score	Significance	Sector Score
18. In the last month have you seen any errors, near misses or incidents that could have hurt staff and/or patients/service users?	35.5%	Significantly Declined	41.0%	Significantly Worse	35.3%
19a. My organisation treats staff who are involved in an error, near miss or incident fairly.	62.4%	Not Significant	64.8%	Significantly Better	60.4%
19b. My organisation encourages us to report errors, near misses or incidents.	88.6%	Not Significant	87.2%	Not Significant	85.6%
19c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	68.5%	Not Significant	68.0%	Not Significant	68.9%
19d. We are given feedback about changes made in response to reported errors, near misses and incidents.	59.4%	Not Significant	59.2%	Significantly Worse	62.0%

(4) We are safe and healthy

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 4 - We are safe and healthy	6.14	Not Significant	6.05	Not Significant	6.09
People Promise 4, Subscore 1 - Health and safety climate	5.44	Not Significant	5.34	Significantly Worse	5.51
3g. I am able to meet all the conflicting demands on my time at work.	44.3%	Significantly Declined	40.3%	Significantly Worse	47.6%
3h. I have adequate materials, supplies and equipment to do my work.	57.0%	Significantly Declined	53.0%	Significantly Worse	56.3%
3i. There are enough staff at this organisation for me to do my job properly.	29.6%	Not Significant	29.5%	Significantly Worse	33.3%
5a. I have unrealistic time pressures.	23.7%	Not Significant	24.5%	Not Significant	25.8%
11a. My organisation takes positive action on health and well-being.	59.4%	Not Significant	61.0%	Significantly Better	56.7%
13d. The last time you experienced physical violence at work, did you or a colleague report it?	64.0%	Not Significant	68.2%	Not Significant	70.0%
14d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	52.8%	Not Significant	47.6%	Not Significant	51.5%

People Promise 4, Subscore 3 - Negative experiences		7.95	Not Significant	7.83	Not Significant	7.78
11b.	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	26.8%	Not Significant	29.1%	Not Significant	31.1%
11c.	During the last 12 months have you felt unwell as a result of work related stress?	41.0%	Significantly Declined	44.6%	Significantly Worse	42.2%
11d.	In the last three months have you ever come to work despite not feeling well enough to perform your duties?	54.9%	Not Significant	56.7%	Not Significant	56.1%
13a.	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	11.1%	Significantly Declined	13.5%	Not Significant	14.1%
13b.	In the last 12 months how many times have you personally experienced physical violence at work from managers?	0.7%	Not Significant	0.4%	Significantly Better	0.9%
13c.	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	1.2%	Not Significant	1.8%	Not Significant	2.2%
14a.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	19.6%	Not Significant	22.2%	Significantly Better	25.2%
14b.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	9.6%	Not Significant	8.9%	Not Significant	9.6%
14c.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	20.2%	Not Significant	18.7%	Not Significant	18.4%

Additional – Health, wellbeing and safety at work

Question		2023 Score	Significance	2024 Score	Significance	Sector Score
10b.	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	37.8%	Not Significant	39.9%	Significantly Worse	37.4%
10c.	On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	49.4%	Not Significant	50.8%	Not Significant	49.5%
11e.	Have you felt pressure from your manager to come to work?	20.5%	Not Significant	17.2%	Significantly Better	21.0%

(5) We are always learning

People Promise/Theme/Question		2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 5 - We are always learning		5.65	Not Significant	5.75	Not Significant	5.69
People Promise 5, Subscore 1 - Development		6.66	Not Significant	6.61	Significantly Better	6.41
24a.	This organisation offers me challenging work.	72.5%	Not Significant	72.0%	Significantly Better	67.2%
24b.	There are opportunities for me to develop my career in this organisation.	58.8%	Not Significant	57.7%	Not Significant	55.5%
24c.	I have opportunities to improve my knowledge and skills.	74.3%	Not Significant	72.2%	Significantly Better	69.6%
24d.	I feel supported to develop my potential.	58.9%	Not Significant	59.5%	Significantly Better	55.9%
24e.	I am able to access the right learning and development opportunities when I need to.	63.1%	Not Significant	60.2%	Not Significant	59.1%

Additional – Personal development

Question		2023 Score	Significance	2024 Score	Significance	Sector Score
23a.	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	79.4%	Not Significant	80.6%	Significantly Worse	85.6%
24f.	I am able to access clinical supervision opportunities when I need to.	-	N/A	57.9%	Significantly Better	54.3%

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 6 - We work flexibly	6.39	Not Significant	6.47	Significantly Better	6.22
People Promise 6, Subscore 1 - Support for work-life balance	6.34	Not Significant	6.44	Significantly Better	6.29
6b. My organisation is committed to helping me balance my work and home life.	48.4%	Significantly Improved	52.2%	Significantly Better	49.1%
6c. I achieve a good balance between my work life and my home life.	54.9%	Not Significant	55.3%	Not Significant	55.6%
6d. I can approach my immediate manager to talk openly about flexible working.	70.1%	Significantly Improved	74.0%	Significantly Better	69.4%
People Promise 6, Subscore 2 - Flexible working	6.43	Not Significant	6.49	Significantly Better	6.15
4d. The opportunities for flexible working patterns.	60.0%	Not Significant	61.7%	Significantly Better	55.9%

(7) We are a team

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
People Promise 7 - We are a team	6.85	Not Significant	6.91	Significantly Better	6.74
People Promise 7, Subscore 1 - Team working	6.77	Not Significant	6.71	Not Significant	6.68
7a. The team I work in has a set of shared objectives.	76.4%	Not Significant	74.8%	Not Significant	73.6%
7b. The team I work in often meets to discuss the team's effectiveness.	63.0%	Not Significant	63.6%	Not Significant	61.9%
7c. I receive the respect I deserve from my colleagues at work.	69.6%	Not Significant	70.5%	Not Significant	70.8%
7d. Team members understand each other's roles.	72.2%	Not Significant	70.0%	Not Significant	71.1%
7e. I enjoy working with the colleagues in my team.	82.4%	Not Significant	81.0%	Not Significant	79.9%
7f. My team has enough freedom in how to do its work.	64.0%	Significantly Declined	60.5%	Not Significant	60.2%
7g. In my team disagreements are dealt with constructively.	56.7%	Not Significant	58.1%	Not Significant	56.5%
8a. Teams within this organisation work well together to achieve their objectives.	55.0%	Not Significant	53.5%	Not Significant	55.5%
People Promise 7, Subscore 2 - Line management	6.94	Significantly Improved	7.12	Significantly Better	6.81
9a. My immediate manager encourages me at work.	72.6%	Significantly Improved	76.4%	Significantly Better	71.5%
9b. My immediate manager gives me clear feedback on my work.	65.1%	Significantly Improved	68.5%	Significantly Better	64.7%
9c. My immediate manager asks for my opinion before making decisions that affect my work.	61.2%	Not Significant	62.5%	Significantly Better	58.8%
9d. My immediate manager takes a positive interest in my health and well-being.	71.9%	Not Significant	74.9%	Significantly Better	69.3%

Dorset County Hospital
NHS Foundation Trust

Report to	DCH Board of Directors	
Date of Meeting	8th April 2025	
Report Title	Equality Diversity and Inclusion Annual Report and Action Plan (DCH)	
Prepared By	Jan Wagner (Equity, Diversity, Inclusion & Belonging Lead)	
Approved by Accountable Executive	Nicola Plumb Joint Chief People Officer	
Previously Considered By	Senior Leadership Group (SLG) - 20th March 2025 People and Culture Committee in Common - 24th March 2025	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	
Financial	Failure to comply with the Public Sector Equality Duty (PSED) could pose significant risks to the organisation, including financial penalties.	
Statutory & Regulatory	The development of fair and inclusive leadership, practices, and organisational culture supports the 'Well-Led' domain of the CQC framework. Inclusive workplaces are associated with improved staff health and wellbeing, which in turn is strongly linked to higher levels of patient satisfaction and improved clinical outcomes. Consequently, advancements in Equality, Diversity, and Inclusion (EDI) initiatives have the potential to positively impact all CQC domains.	
Equality, Diversity & Inclusion	Promoting Equality, Diversity, and Inclusion is a core commitment within the Trust's Social Value pledge, reflecting its dedication to fostering a fairer, more inclusive environment that benefits both staff and the wider community.	
Co-production & Partnership	**"We work together as one community to provide outstanding quality of care, in an environment where diverse voices are not only heard but valued, where differences are celebrated as sources of strength, and where discrimination has no place"**– The Trust Joint Inclusion & Belonging Strategy signals our intention to truly value our staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.	

Executive Summary

This year's EDIB Annual Report highlights significant progress in embedding equity, diversity, inclusion, and belonging across the organisation. However, it also identifies persistent challenges that require strategic focus and leadership commitment moving forward. While workforce diversity has improved in some areas, disparities in recruitment, progression, and leadership representation remain. EDS2 self-assessments indicate that senior leadership engagement with inclusion efforts must be strengthened to move beyond compliance and toward meaningful change.

In addition to structural representation gaps, the report underscores concerning differences in the lived experiences of Black, Asian, minority ethnic, and disabled colleagues. WRES and WDES data reveal disparities in career progression, formal disciplinary processes, and workplace harassment reports, highlighting the urgent need to address workplace equity and psychological safety. The introduction of an anonymous staff-on-staff reporting system is a step in the right direction, but ongoing efforts are necessary to build trust and accountability within the organisation.

Beyond workforce data, the report stresses the importance of embedding inclusion in everyday decision-making rather than viewing it as a compliance exercise. The transition from a Staff Network Charter to a formal policy has provided stronger governance and resourcing for networks, yet ensuring their continued influence in strategic decisions remains a priority. Similarly, the revised Equality Impact Assessment (EIA) process is designed to integrate inclusion more deeply into decision-making structures, but sustained monitoring is required to ensure its full effectiveness.

Another key concern highlighted in this report is sexual safety in the workplace. Despite the introduction of new policies and training initiatives, staff survey data indicates that sexual misconduct remains an issue. The implementation of the Sexual Misconduct Policy, along with sexual safety training, will need to be closely monitored to ensure that cultural change is not only promoted but actively reinforced.

Finally, workforce well-being continues to be impacted by structural barriers, including the lack of affordable staff accommodation. This issue remains a significant challenge for recruitment and retention, and the upcoming long-term accommodation strategy will be critical in addressing it. Additionally, strengthening engagement between senior leaders and staff networks remains a key focus, with the Joint Staff Network Conference playing an important role in breaking down barriers and fostering inclusive dialogue.

Moving forward, embedding inclusion as a lived reality rather than a policy commitment will require a sustained, action-oriented approach. Senior leadership must take an active role in EDIB initiatives beyond compliance and reporting obligations, ensuring that inclusive policies translate into real workplace experiences. Sponsors and managers will need to be held accountable for fostering psychologically safe environments, while cross-network collaboration must be strengthened to amplify voices and drive system-wide change. Inclusion must not be seen as a separate function but as an integral part of workforce practices and patient care models, ensuring that cultural transformation is reflected in measurable and meaningful outcomes.

Recommendation

The Board are requested to:

- Receive the Equality Diversity and Inclusion Annual Report and Action Plan for **approval**.

Equity, Diversity, Inclusion & Belonging Annual Report 2024

Authors	Jan Wagner (Equality, Diversity, Inclusion & Belonging Lead)
Purpose of Report	This report provides an overview of our Equity, Diversity, Inclusion & Belonging (EDIB) activity and outcomes during 2024, along with planned steps for 2025.

Executive Summary

This report provides an overview of our Trust's Equity, Diversity, Inclusion and Belonging (EDIB) activities for 2024, highlighting key achievements and areas requiring further focus. It reflects our commitment to meeting statutory obligations and advancing an inclusive culture.

We have fulfilled our obligations under the Equality Act 2010 and the Public Sector Equality Duty (PSED), submitting reports on:

- Workplace Race Equality Standard (WRES)
- Workplace Disability Equality Standard (WDES)
- Gender Pay Gap (GPG)
- Equality Delivery System (EDS2)

These reports were presented to the Board in accordance with our annual reporting cycle.

A key milestone was the approval of our Joint Inclusion and Belonging Strategy 2024-2026, developed with our partner organisation Dorset HealthCare. This strategy embeds inclusion across every stage of the colleague experience—from attraction and recruitment through development, retention, and transition. It is grounded in data and emphasises that inclusion is a collective responsibility. Our vision is clear: "we work together as one community to provide outstanding quality of care, in an environment where diverse voices are not only heard but valued, where differences are celebrated as sources of strength, and where discrimination has no place"

The strategy centres on four key pillars, identified through workforce data and areas requiring attention:

Our Inclusion and Belonging Action Plan outlines measurable targets and timelines, holding us accountable for progress, with completion goals set for 2026. Regular reviews will ensure agility to adapt to workforce needs. In alignment with the NHS equality, diversity, and inclusion improvement plan, we aim to tackle discrimination—both direct and indirect—within behaviours, policies and procedures. We remain committed to building an organisation where every colleague feels heard, respected, and valued.	
Recommendation	The Board and People & Culture Committee in Common are asked to note the annual progress alongside the proposed priorities for the year ahead, as per our Inclusion and Belonging Strategy 2024-2026.

Equity, Diversity, Inclusion & Belonging (EDIB) Annual Report 2024

Background

This report outlines the background and context for our Trust's Equity, Diversity, Inclusion and Belonging (EDIB) activities during 2024, providing transparency on our commitments and progress.

We are required to publish equality information annually, in line with the Equality Act 2010, to demonstrate compliance with our Public Sector Equality Duty (PSED). Beyond this legal obligation, we are committed to being open about our ongoing work to build an inclusive culture across our organisation.

This report offers a high-level overview of Trust-wide activities in 2024 and highlights areas for improvement and future focus. It also summarises the national NHS frameworks that guide and support our work, as mandated in the NHS Standard Contract. Previous reports on these frameworks have been submitted to the Board in line with our annual reporting cycle.

We continue to report against the following national NHS frameworks:

- The Equality Delivery System 2 (EDS2), which is for both staff and patients
- The Workforce Race Equality Standard (WRES), which is for staff
- The Workforce Disability Equality Standard (WDES), which is for staff
- Gender Pay Gap (GPG) reporting for staff

These frameworks are integral to our inclusion strategy and help us identify gaps, set measurable goals, and track progress in fostering a more equitable and inclusive organisation.

Our Vision

Our vision for 2025/26 is to embed inclusivity in everything we do, ensuring we are truly representative of the community we serve and the wider NHS. We are committed to valuing our people and fostering a sense of belonging within a culture that is open, compassionate, fair, and inclusive. Our aim is to create better working lives for our people, which leads to better outcomes for our organisation and more meaningful experiences for our patients.

We have further refined our vision by committing to: “Working together as one community to provide outstanding quality of care, in an environment where diverse voices are not only heard but valued, where differences are celebrated as strengths, and where discrimination has no place.”

Our Performance against National NHS Frameworks

Participating in national NHS reporting frameworks extends beyond statutory obligations. It enhances accountability, drives meaningful action to advance workplace equity, and enables us to measure progress transparently. By engaging in these frameworks, we clearly demonstrate where we are and identify what further actions are needed to foster a culture of inclusion and belonging at Dorset County Hospital.

Equality Delivery System (EDS2) objectives

The Equality Delivery System (EDS2) is a national framework designed to help NHS organisations improve service delivery, meet the requirements of the Equality Act 2010, and support the Public Sector Equality Duty. In 2022/23, we were unable to complete the EDS2 process due to the vacancy in the EDIB Lead position. However, in 2024, we fully implemented the framework, using it as a benchmark for our progress in advancing equity and inclusion. As part of this process, we conducted a self-assessment and scored our performance against each EDS2 domain to identify strengths and areas for improvement.

- Domain 1 is a focused review of a specific service or services and was completed as part of the Dorset ICS collaborative approach to the EDS. For 2023/24 we have reviewed elements of three different services across the system, in line with the guidance. The three services are:

    1. Ethnicity Reporting
    2. Targeted Lung Health Checks
    3. Learning Disability Alerts

    The overall sore here is **‘achieving’**.

- Domain 2 assesses practice in relation to workforce health and wellbeing; in three sub-sections we are scored ‘**developing’** and in one we are ‘**achieving**’.
    - To score ‘achieving’ in 2a Health monitoring data is collated and the Trust would use sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment.
    - And the organisation would provide support to staff who have protected characteristics
    - To score ‘achieving’ in 2b we need a zero-tolerance policy for verbal and physical abuse towards staff and penalises staff who abuse, harass or bully other members of staff and takes action to address and prevent bullying behaviour and closed cultures, recognising the link between staff and patient experience.
    - To score ‘excelling’ in 2c the Trust facilitates pooling union representatives with partner organisations, to encourage independence and impartiality. And relevant staff networks are … “provided protected time to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source.” Appropriate resourcing for staff networks to be in place.
    - To score ‘achieving’ in 2d the Trust should compare the experiences of LGBT+ staff against other staff members and reach an average recommendation rate over 70% (85% for Excelling)

- Domain 3 assesses 'Inclusive Leadership' and relates to evidence that the Board and senior leaders in the Trust and wider system are working with and acting on equality and health inequalities. In two sub scores we have self-assessed as '**developing**' and in one **'achieving.'**
    - To score 'achieving' in 3a **all board members** and **senior leaders** meet staff networks at least 3 or more times a year and engage and sponsor religious, cultural or local events and celebrations.
    - To score 'excelling' in 3b Equality Impact Assessments are completed for **all** projects and policies and are signed off at the appropriate level where required.
    - To score 'achieving' in 3c those holding roles at AFC Band 8C and above are reflective of the population served.

The overall self-rated score of 16 is considered '*developing'*. A specific improvement plan is included as part of the EDS template and its findings will also be taken forward into our wider programmes for equality, inclusion, wellbeing and reducing health inequalities. These actions also align to our newly developed Joint Inclusion and Belonging strategy.

The full report can be accessed via: dchft.nhs.uk/wp-content/uploads/2025/02/Equality-Delivery-System-EDS2-DCHFT-Report-and-Action-Plan-2024.pdf

Workforce Race Equality Standard (WRES)

The WRES sets out a national framework through which Trusts are required to measure their performance against nine key indicators for staff representation and experience regarding race. These include workforce indicators (1-4), Staff Survey indicators (5-8) and an indicator based on Board representation (9). Unfortunately, some numbers have dropped, especially on indicator 2.

Indicator	Description	2022/23 result	2023/24 result
1	Percentage of black and minority ethnic (BME) staff	**15.33%**	**18.74%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	White applicants are **1.51** times more likely	White applicants are **5.57** times more likely
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	BME staff are **0** times more likely	BME staff are **1.2** times more likely
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff	White staff are **1.05** times more likely	White staff are **0.81** times less likely
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: **25%** BME: **29.8%**	White: **18%** BME: **22%**

6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White: **24.9%** BME: **32.4%**	White: **22.6%** BME: **25.8%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	White: **60.7%** BME: **47%**	White: **58.1%** BME: **59.3%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	White: **6.1%** BME: **16.6%**	White: **7.8%** BME: **18%**
9	BME board membership	**8.3%**	**7.14%**

The full report can be accessed via: https://www.dchft.nhs.uk/wp-content/uploads/2024/10/Workforce-Race-Equality-Standard-Report-2024.pdf

Next steps

A key priority this year has been adopting an evidence-based approach in designing and implementing our first joint Inclusion and Belonging Strategy with Dorset HealthCare. This strategy includes a comprehensive action plan, consolidating all activities under NHS England's EDI statutory reporting obligations. Despite resource challenges within the EDI team, we have made steady progress, achieving the following milestones:

- Dorset County Hospital implemented system-wide Conscious Inclusion and Inclusive Leadership training predominantly for line managers.
- We actively supported the Overseas Staff Network and the Ethnic Diversity Network with their initiatives and activities.
- Using the NHSE template, we have developed a new Sexual Misconduct Policy, which is currently progressing through the ratification process.
- A new anonymous reporting system has been purchased to enable staff to report concerns about staff behaviour securely.

WRES activities currently in progress will continue into 2025. We have reviewed and updated our latest action plan based on the most recent WRES data to ensure our efforts are data-driven and impactful.

Workforce Disability Equality Standard (WDES)

The WDES sets out a national framework through which Trusts are required to measure their performance against ten key measures (metrics). This enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. Overall, we have seen some improvements from last year but also declines on three figures.

Metric	Description	2022/23 result	2023/24 result

1	Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce	Due to the low percentage of staff recorded as having a disability on the ESR (4.88%) it has not been possible to draw meaningful conclusions from this data.	Due to the low percentage of staff recorded as having a disability on the ESR (4.88%) it has not been possible to draw meaningful conclusions from this data.
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts	**1.14** (A figure below 1.00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting)	**0.56** (A figure below 1.00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting)
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	**4.24** (A figure above 1.00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process)	**2.83** (A figure above 1.00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process)
4	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public	Disabled: **28.8%** Non-Disabled: **24.5%**	Disabled: **22.8%** Non-Disabled: **17.1%**
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	Disabled: **16%** Non-Disabled: **9.9%**	Disabled: **14.5%** Non-Disabled: **7.5%**
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	Disabled: **28.8%** Non-Disabled: **18.9%**	Disabled: **24.2%** Non-Disabled: **18%**
	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled: **52%** Non-Disabled: **42%**	Disabled: **53.6%** Non-Disabled: **51.6%**

5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion	Disabled: **59.1%** Non-Disabled: **58.6%**	Disabled: **55.3%** Non-Disabled: **59.3%**
6	Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled: **28.6%** Non-Disabled: **18%**	Disabled: **24.5%** Non-Disabled: **18%**
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled: **36.5%** Non-Disabled: **46.4%**	Disabled: **36.8%** Non-Disabled: **48.4%**
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	**71.9%**	**70.3%**
9	NHS Staff Survey and the engagement of Disabled Staff: The engagement score for Disabled staff, compared to non-disabled staff	Disabled: **6.6** Non-Disabled: **7.1**	Disabled: **6.7** Non-Disabled: **7.2**
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: a) By Voting Membership of the Board	This year, it was not possible to extract reliable data for comparison purposes on this metric due to the introduction of new joint roles and lack of access to the ESR data for members on the DHC ESR system.	This year, it was not possible to extract reliable data for comparison purposes on this metric due to the introduction of new joint roles and lack of access to the ESR data for members on the DHC ESR system.
	b) By Executive membership of the Board		

The full report can be accessed via: https://www.dchft.nhs.uk/wp-content/uploads/2024/10/Workforce-Disability-Equality-Standard-Report-2024.pdf

Next steps

A key priority this year has been adopting an evidence-based approach to designing and implementing our first joint Inclusion and Belonging Strategy with Dorset County Hospital. This strategy incorporates an overarching action plan, consolidating all actions under NHS England's EDI statutory reporting obligations. Despite resource challenges within the EDI team, we have achieved meaningful progress, completing the following actions:

- Dorset County Hospital delivered system-wide Conscious Inclusion and Inclusive Leadership training for line managers.
- Provided dedicated support to the Without Limits staff network, enabling them to advance their initiatives.
- Developed a new Sexual Misconduct Policy based on the NHSE template, which is currently in the ratification process.
- Procured a new anonymous staff-on-staff reporting system to address workplace concerns securely.

WDES-related activities will continue into 2025, with the most recent action plan reviewed and updated based on the latest data to ensure continuous improvement and impact.

Gender Pay Gap (GPG)

Organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The requirements of the mandate are within the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. The GPG is a measure of workplace disadvantage via a comparison between men's and women's average hours of pay, it is different to equal pay, where men and women must be paid the same or equal for similar work. Organisations can build a narrative through analysis of their data to look at factors which may be contributing to any pay gap such as occupational segregation or caring responsibilities and part-time roles being shared unequally.

Across our entire workforce our mean gender pay gap for 2023 was 21%. This means that the average hourly pay rate for men is 21% higher than for women. This is a 4% reduction to the pay gap of 25% recorded in 2022, and 5% less than that recorded in 2021 (26%). Our overall median gender pay gap is 5.53%. This means that the mid-point hourly rate for men is 5.53% higher than for women. This is an improvement of 2.47% on 2022's reported 8% and continues the improving trend against the 9% reported in 2021.

The full report can be accessed via: https://www.dchft.nhs.uk/wp-content/uploads/2024/03/Gender-Pay-Gap-Report-2023.pdf

External Accreditations

External accreditations demonstrate our on-going commitment to EDI, ensuring we meet and maintain the required standards as well as supporting our attraction strategy by showing us an inclusive and caring employer of choice:

- Holding the **Disability Confident Employer Level 1** status and taking steps to apply for Level 2: The Disability Confident scheme aims to help employers make the most of the opportunities provided by employing disabled people

- Acting on the commitments in the **Armed Forces Covenant**: Together we acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy, and society they serve with their live. We hold currently the Silver Status and are aiming for the Gold Status.

Key successes

Since January 2024, our EDI Lead has been actively driving our inclusion agenda, supported partly by our Organisational Development Projects and Inclusion Facilitator. During this period, we have focused on improving our inclusion strategies by developing a comprehensive Inclusion and Belonging Strategy for 2024–2026. This strategic framework is designed to not only renew our commitment to equity, diversity, and inclusion but also to establish a culture of belonging across our organisation.

Key successes over the past 12 months are:

✓ **Staff Networks:** Our five staff networks continue to evolve as powerful cultural ambassadors within the Trust, playing a pivotal role in fostering an inclusive environment. These networks are integral to understanding and addressing the needs and priorities of our workforce, particularly those from underrepresented groups. Our current networks include:

- Without Limits
- Overseas Staff Network
- Ethnic Diversity Network
- Pride Network
- Armed Forces Support Network

Our staff-led networks are essential in bridging gaps, amplifying underrepresented voices, and influencing positive change within the Trust. They are not only forums for support and community but also strategic partners in driving cultural transformation. Over the past year, our staff networks have demonstrated exceptional leadership and initiative in advancing our inclusion goals. Their contributions have significantly shaped our organisational culture and informed our strategic priorities. Here are some of the notable accomplishments from the past year:

Activity	Networks Involved
Marking National Campaigns	Our Pride Network has played a leading role in ensuring the Trust's active participation in key national and local inclusion campaigns. A standout achievement was the organisation of our presence at BourneFree Pride (Bournemouth Pride), where we proudly marched alongside colleagues from across the Trust. Fostering wider collaboration and visibility, the network also extended an invitation to Dorset HealthCare, strengthening our collective commitment to LGBTQIA+ inclusion within the healthcare system. Beyond Pride, our networks have been raising awareness and sharing lived experiences across the Trust and the wider healthcare system. They have actively contributed to system-wide awareness and celebration events, including LGBTQ+ History Month, where they have delivered presentations, facilitated discussions,

	and shared personal stories to deepen understanding and allyship across our workforce. These events serve not only as moments of celebration but also as opportunities for meaningful engagement, education, and advocacy. By amplifying the voices of our LGBTQIA+ colleagues, our networks are helping to shape a more inclusive and supportive culture within the Trust and beyond.
Regular education	Our Without Limits Network is dedicated to promoting continuous learning and understanding within the Trust by facilitating regular educational opportunities. As part of their commitment to fostering an inclusive workplace, they organise monthly meetings featuring guest speakers who share their lived experiences and provide valuable insights relevant to all staff members. These sessions are designed to not only educate but also inspire empathy and allyship across our workforce. By presenting diverse perspectives and highlighting real-world challenges, the Without Limits Network contributes significantly to enhancing cultural competency and breaking down barriers within the Trust. These educational initiatives play a crucial role in nurturing an environment where every voice is heard, and every individual feels valued. Through open dialogue and shared learning, we continue to grow as an inclusive and supportive organisation.
Peer Support	Our staff networks serve as vital peer support communities, ensuring that colleagues have access to guidance, encouragement, and a sense of belonging within the Trust. Most of our networks hold monthly meetings, where members can come together in a safe and supportive space to share experiences, discuss challenges, and collaborate on solutions. Beyond these structured meetings, the support extends organically across the organisation. Chairs and Co-Chairs play a crucial role in providing ongoing, ad hoc support, offering advice, signposting resources, and acting as trusted points of contact for colleagues who may need guidance at any time. This peer-led approach not only strengthens individual resilience but also contributes to a more compassionate and inclusive workplace. By fostering a culture where colleagues feel supported both formally and informally, our networks are instrumental in ensuring that everyone, regardless of background or identity, feels heard, valued, and empowered.
EDI Specialist Support	Our Equity, Diversity, Inclusion, and Belonging (EDIB) Lead plays an active role in supporting and amplifying the work of our staff networks by attending monthly meetings. These sessions provide a crucial platform for knowledge-sharing, cross-network collaboration, and collective problem-solving, ensuring that the voices of our diverse workforce are heard and acted upon. A key focus of these meetings is to identify common themes and emerging challenges across networks, ensuring that our EDIB efforts remain actionable and impactful. By facilitating discussions and aligning priorities, we create opportunities for joint initiatives that not only support individual networks but also enhance intersectionality—recognising the interconnected nature of different lived experiences and ensuring that inclusion efforts are holistic and representative of all identities within our workforce. The outcomes of these discussions are directly reflected in our EDIB Action Plan (see Appendix), which outlines concrete steps

	taken to address identified challenges, drive meaningful change, and measure our progress in fostering an inclusive workplace. This collaborative approach ensures that our EDI strategy remains dynamic and responsive to the evolving needs of our colleagues. In addition to the work led by the EDIB Lead and staff networks, other members of the Organisational Development (OD) Team play a key role in advancing inclusion. Our Leadership & Personal Development Lead has delivered bitesize sessions on neurodiversity to support managers in balancing inclusive workplace adjustments with effective performance and conduct management. Furthermore, they are actively contributing to the Development Programme for Specialty Doctors from Overseas, ensuring that internationally trained clinicians receive the tailored support and professional development they need to thrive within our organisation. By fostering open dialogue, shared learning, and cross-functional collaboration, we continue to build a truly inclusive and supportive working environment for everyone.

✓ **Conscious Inclusion and Inclusive Leadership Training:**
Dorset County Hospital has taken a proactive role in the development and implementation of a system-wide Conscious Inclusion and Inclusive Leadership training programme. Designed collaboratively to promote inclusive practices, this comprehensive training package has been delivered across all NHS trusts in Dorset, as well as to primary care providers and local councils, fostering a unified approach to inclusion across the region.

Dorset County Hospital is the only organisation within this network to deliver the training in person, recognising the value of face-to-face interaction in enhancing engagement and learning outcomes. Feedback has been overwhelmingly positive, with participants highlighting the effectiveness and impact of in-person sessions compared to virtual alternatives.

The training is primarily targeted at line managers, equipping them with the knowledge and tools needed to lead inclusively and consciously. A unique feature of this programme is the commitment to actionable change: participants are encouraged to make 'inclusion pledges' at the end of each session. These pledges, collected system-wide, serve as tangible demonstrations of personal commitment to fostering a more inclusive workplace.

To ensure accountability and sustained impact, follow-up contact will be made with participants to track their progress on their pledges. This ongoing engagement reinforces a culture of continuous learning and commitment to inclusion. Additionally, Dorset County Hospital has offered further internal sessions to its staff, reinforcing its dedication to developing inclusive leadership at every level of the organisation.

Through this strategic and hands-on approach, Dorset County Hospital is not only leading by example but also driving cultural change across the wider healthcare system. This initiative is a testament to our commitment to nurturing conscious, inclusive leaders who can inspire and sustain an environment where every individual feels valued and empowered.

✓ **Sexual Safety in DCH:**
Since signing up to the Sexual Safety Charter, Dorset County Hospital has made significant strides in promoting sexual safety and fostering a respectful work environment. We are fully committed to ensuring that all staff feel safe, supported, and respected in the workplace, and our proactive measures reflect this commitment.

One of our key achievements has been the adaptation of the NHS England template for a Sexual Misconduct Policy. This policy has been carefully tailored to meet the specific needs of our workforce and is now in the final stages of ratification. Once implemented, it will provide clear guidance and robust procedures for addressing sexual misconduct, ensuring accountability and offering support to those affected.

To further enhance safety and reporting mechanisms, we have invested in an anonymous reporting system specifically designed to address staff-on-staff concerns, including issues related to Freedom to Speak Up Guardians (FTSUG). This system will enable employees to report concerns confidentially and securely, ensuring that all voices are heard without fear of retaliation.

Recognising the importance of education in preventing sexual misconduct, we have made sexual safety training mandatory for all staff. In addition, we have strategically woven sexual safety modules into existing training programmes, ensuring that all employees are consistently informed and aware of the standards of behaviour expected within the Trust. This integrated approach reinforces a culture of respect and accountability across all levels of the organisation.

To foster open dialogue and raise awareness, we launched a comprehensive communication campaign featuring videos from senior executives. This initiative underscores leadership's unwavering commitment to sexual safety and promotes a culture where concerns can be raised and addressed confidently.

Through these strategic actions, Dorset County Hospital is setting a benchmark in the NHS for creating a safe and respectful workplace. We remain dedicated to continuous improvement and to fostering an environment where every member of staff feels safe, respected, and valued.

- ✓ **Staff Network Policy:**
  The existing staff network charter has been transformed into a comprehensive Staff Network Policy to demonstrate our ongoing commitment to inclusion and to strengthen the role of our staff networks within Dorset County Hospital. This policy not only formalises the influence of staff networks in shaping organisational culture but also ensures dedicated resourcing and support for their continued growth and impact. By transitioning from a charter to a policy, we are reinforcing the strategic importance of these networks as essential voices within our organisation. The policy is currently in the ratification process, and once approved, it will provide a robust framework that empowers our staff networks to effectively advocate for inclusion and drive meaningful change across the Trust.

- ✓ **Equality Impact Assessment (EIA):**
  The EIA process has been thoroughly reviewed and enhanced to integrate more deeply into our daily practices at Dorset County Hospital. To facilitate better understanding and more consistent application, a comprehensive set of guidelines has been added. This guideline provides clear instructions on how to conduct effective EIAs, ensuring that all decisions, policies, and initiatives are evaluated through an inclusive and equitable lens. These improvements aim to strengthen our commitment to fairness and inclusion by making the EIA a fundamental part of our organisational culture and decision-making processes. The revised EIA is currently in the ratification process and, once approved, will further solidify our commitment to embedding equality considerations into all aspects of our work.

Our EDI Objectives and Priorities for the next 12 months

Over the next 12 months, our primary focus will be on the delivery of our new Inclusion and Belonging Strategy 2024-2026. A key element of this strategy is ensuring that our data is accurate and

comprehensive, as reliable metrics are essential for measuring progress and demonstrating the impact of our initiatives. This data-driven approach will allow us to assess our achievements, identify areas for improvement, and maintain accountability.

We have identified the following key priorities for the upcoming months:

- ✓ **Equality Impact Assessment (EIA):**
  With the upcoming ratification of the new EIA, we will actively encourage leaders to utilise and implement it as outlined in the guidelines. These guidelines are designed to help leaders understand and consider the impact of their decisions on different staff groups, ensuring that inclusivity and equity are prioritised in all organisational actions. By embedding the EIA more deeply into daily practice, we aim to create a culture of conscious inclusion across all levels of the organisation.

- ✓ **Sexual Safety:**
  Despite our ongoing efforts, the latest staff survey indicates that instances of sexual misconduct in the workplace continue to be a concern. With the ratification of the new Sexual Misconduct Policy and the implementation of an anonymous reporting system, we will sustain our commitment to sexual safety through continued education and awareness initiatives. This includes mandatory training and integrated learning modules designed to empower staff with the knowledge and tools needed to maintain a respectful workplace. Our objective is to foster a culture where all employees feel safe and supported, ensuring that any instances of misconduct are promptly addressed and prevented.

- ✓ **Joint EDIB Policy:**
  While the new Inclusion and Belonging Strategy marks significant progress, we recognise the importance of establishing a long-term commitment to equity, diversity, inclusion, and belonging (EDIB). To achieve this, we are developing a Joint EDIB Policy in collaboration with Dorset HealthCare. This policy is designed to embed EDIB principles into every aspect of our organisation, ensuring they are deeply integrated into our culture and operations. Dorset County Hospital is leading this joint effort, setting the standard for inclusive practices across the region and reinforcing our dedication to sustainable cultural change.

- ✓ **Long-term accommodation plan for staff:**
  One of the most pressing challenges faced by our workforce is the availability of affordable accommodation. In line with our Inclusion and Belonging Strategy, we are committed to developing a robust and long-term plan to address this issue. We will encourage the relevant departments to think creatively and explore all available options, including partnerships with local housing providers, flexible accommodation arrangements, and other innovative solutions. Our goal is to ensure that all staff, regardless of background or financial situation, have access to secure and affordable housing.

- ✓ **Engagement between senior leaders and staff groups:**
  Strengthening the relationship between senior leaders and staff groups is crucial for fostering an inclusive and collaborative workplace culture. To bridge this gap, we are prioritising open dialogue and engagement initiatives. A key starting point will be the Joint Staff Network Conference organised in partnership with Dorset HealthCare. This conference aims to break down communication barriers and provide a platform for candid discussions on challenges and opportunities. By creating an environment where leaders and staff can communicate on an equal level, we aim to build stronger connections and find solutions collaboratively.

These priorities reflect our commitment to advancing equity, diversity, inclusion, and belonging throughout Dorset County Hospital. By maintaining a strategic focus on these areas, we are confident

that we can continue to create a workplace where every individual feels valued, respected, and empowered to thrive.

Conclusion

Dorset County Hospital has made meaningful progress in advancing equity, diversity, inclusion, and belonging over the past year. Our efforts, guided by the Inclusion and Belonging Strategy 2024-2026, have laid a solid foundation for creating a more inclusive and supportive workplace. We have taken important steps by enhancing staff networks, implementing system-wide Conscious Inclusion and Inclusive Leadership training, and addressing sexual safety within our organisation. These initiatives reflect our commitment to fostering a culture where all employees feel valued, respected, and empowered.

However, while we acknowledge and celebrate these achievements, it is crucial to recognise that there is still a long way to go. Progress has been made, but significant challenges remain. The latest staff survey results indicate persistent issues, including experiences of sexual misconduct and disparities in representation and opportunity. These findings highlight the ongoing need for a more robust approach to tackling systemic inequalities and building a culture of genuine belonging.

To truly embed equity, diversity, inclusion, and belonging into every aspect of our organisation, we need unwavering and sustained commitment from our leadership. This requires not only strategic direction but also active engagement, accountability, and the allocation of appropriate resources. Leaders at every level must continue to champion these values, listen to underrepresented voices, and take bold, decisive action to address barriers to inclusion.

As we move forward, we will maintain a clear focus on our key priorities, including the implementation of the new Equality Impact Assessment (EIA), continued education on sexual safety, addressing the urgent need for affordable staff accommodation, and fostering meaningful engagement between senior leaders and staff groups. Our commitment to driving cultural change is unwavering, but we recognise that this journey is ongoing and requires continuous effort, reflection, and adaptation.

Dorset County Hospital remains dedicated to creating a workplace that truly reflects the diverse community we serve. However, achieving this vision demands collective responsibility and shared accountability. By maintaining strategic focus, staying transparent about our progress and challenges, and securing the active involvement of our leadership, we can continue to make meaningful strides towards becoming a more inclusive and equitable organisation.

Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on Wednesday 26 March 2025

Chair	David Clayton-Smith, Chair
Executive Lead	Nick Johnson, Chief Strategy, Transformation and Partnerships Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Capacity within the STP team to support the delivery of long term change, transformation and improvement is a constraint. • Primary care partnership working (DCH with Royal Manor Health Care) recognised as extremely positive and embodies collaborative working and service transformation. • Key working housing joint strategy for DCH and DHC will be critical in recruiting and retaining staff. • The DCH Digital recovery plan is making good progress, but challenges remain.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • Our Dorset Collaborative The committee received a verbal summary highlighting the collaborative work programmes that are underway and planned across the Dorset system. • One Transformation Progress Report incl. strategy enabling plan update The committee received an update on the One Transformation Approach including the strategic portfolios of change and key activity in the period. The capacity to deliver the scale of future change, transformation and improvement is a constraint therefore prioritisation and a robust delivery plan will be critical. • Joint Health Inequalities Annual Plan & Health Inequalities Workstream Update, including progress against plan The committee received an update on progress against the Q4 workplan including establishment of a Joint Health Inequalities Steering Group which met for the first time in March 2025. Cross-organisational work is underway to inform and progress a Health Inequalities plan for 2025/26. • Patient Care Race Equality Framework (PCREF) The committee received an update on progress since January 2025 in relation to implementing the Patient Carer Race Equality Framework (PCREF), and assurance that work is progressing in line with contractual expectations by 31 March 2025. • Social Value Annual Plan

The committee received a summary of the DCH Social Value annual plan for approval noting that a joint approach with DHC has now commenced with the setting up of joint social value operational group commencing in April 2025 and a plan to develop a joint plan for 2026/27.

- Primary Care Partnership
  The committee received a summary of the proposal for DCH to partner with Royal Manor Health Care as a first step to a broader strategy of working more closely alongside general practice.
- Dorset Renal Development Strategic Case
  The committee received a summary of the strategic business case for improvements in in-centre haemodialysis across Dorset and South Somerset over the next 5-10 years, and the next steps in producing a business case for funding approval.
- Cyber security and risk updates
  The committee received an update on the cyber security related activities for DCH and DHC. The development of a system wide Cyber Security Strategy continues led by Dorset ICB with input from DHC, DCH and UHD.
- DCH Digital Recovery Plan – Assurance
  The committee received an update on the DCH digital recovery plan highlighting a number of activities to help address historical issues and BAU backlogs such as clinical risk assessment of systems. Assurance was given that activities will be reviewed every fortnight as part of the recovery plan.
- Policies
  A cleanse of the policy system is underway at DHC to ensure the right policies are in the correct portfolios as outlined in committee terms of reference and whether the documents are obsolete. The committee were assured a process is in place to be complete by May 2025 for DHC with implementation for DCH in March 2026.
- Frailty Hospital at Home
  The committee received a presentation on the hospital at home care model for people living with frailty offering a community-based alternative to hospital admission for patients with acute needs. There have been many positive impacts and outcomes in the last 18 months and committee members commended the team on their achievements

The following escalation reports from sub groups were received for assurance by the committee members:

DCH:

- Digital Transformation and Assurance Group (DTAG)
- NHP Programme Board Assurance Report

Decisions made at the meeting	• DCH Social Value Programme Annual Plan was approved. • DCH partnership with Royal Manor Health Care was approved. • The Joint Key Worker Housing Strategy was approved. • The creation of a Quality Committee in Common and Mental Health Legislation board level Committee in common was endorsed and approved by the committee
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance				
	23/09/2024	**25/11/2024**	**27/01/2025**	**24/03/2025**
Quorate?	Y	Y	Y	Y
Dave Underwood	Y	Y	Y	Y
Chris Hearn	Y	Y	Y	N
Rachel Small	Y	Y	Y	N
Anita Thomas	Y	Y	Y	N
Andreas Haimbock-Tichy	N	Y	N	N
Frances West			Y	N
Lucy Knight			Y	Y
Alastair Hutchison		Y		N
Rachel Wharton			Y	
Stephen Tilton	Y	Y	Y	
Nick Johnson	Y	Y	Y	Y

Report to	Board of Directors – Part 1	
Date of Meeting	8th April 2025	
Report Title	DCH Digital Recovery Plan	
Prepared By	Stephen Docherty (interim) Joint Chief Digital Information Officer	
Approved by Accountable Executive	Nick Johnson Chief STP Officer	
Previously Considered By	STP CiC	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Contributes to SR 9 (Digital Infrastructure) & SR 10 (Cyber Security)	
Financial	There are financial implications where there is an identified need to manage digital risks through additional resources.	
Statutory & Regulatory	None arising as a result of this report	
Equality, Diversity & Inclusion	None arising as a result of this report	
Co-production & Partnership	Addressing the risks and agreeing the priorities for the Digital Services team (including the project delivery teams), will be a joint reprioritisation exercise with divisional / operational directors and relevant stakeholders.	

Executive Summary

A previous paper that was brought to STP CiC in January 2025 highlighted the increasing backlog of BAU activities and the challenges impacting the capacity and capability of Digital Services for both DCH and DHC.

This paper specifically focuses on the backlog and issues that need to be addressed at DCH, especially related to the backlog of clinical risk assessments of clinical systems, the overwhelming demand for projects to implement changes, improvements and system upgrades, and the need to supplement resources to address the issues.

A number of improvement activities have been identified to begin addressing the issues and will be reviewed every two weeks with the Chief STP Officer and the digital leadership team.

Improvement activities include:

- Agreeing with divisional directors to free up capacity for clinical colleagues to assist with the backlog of clinical risk assessments.
- Grow the clinical safety officer community through training.
- Establishing more robust project control mechanisms for managing projects and the associated demand.
- Implementing a regular forum for divisional and operational colleagues to engage with the digital teams to discuss and agree on future priorities and tracking of live projects.

- Conducting a 'landscape review' that will document all systems and applications in use across the Trust, including who administers the systems, who uses them, contractual and supplier information. All of which will contribute towards bringing all systems under control, regardless of owner.

JEMT has given support to proceed with three roles that are already within the establishment and are to go through the Recruitment Control Panel (RCP). Further consideration will be given when a business case is presented to seek to increase the capacity of the Clinical Systems Support Team (CSST) which is a major constraint for project delivery and systems upgrades.

Recommendation

Board are requested to:

- Receive the report for **assurance.**

DCH Digital Recovery Plan
Board of Directors 8th April 2025

1. Introduction

1.1. The recent Digital Capacity & Capability report that was brought to STP CiC in January 2025 highlighted a number of concerns related to the provision of Digital Services for both DCH and DHC.

1.2. The report mentioned the issues with the backlog of activities that had accumulated over time as a result of multiple factors such as the funding model (buying hardware with capital instead of developing capabilities), continually working in the same way as teams are too busy dealing with BAU to change, and not having had the mechanisms in place that have led to overwhelming demand for projects and digital changes.

1.3. This report is focused on the DCH backlogs, although collaborating on some of the issues with DHC digital teams will help to share the burden and work together on joint priorities where possible.

1.4. In particular for DCH, the backlogs for Clinical Risk Management (and assessment) for Digital systems has grown to an unacceptable level. The number of projects in the backlog (100+ projects) for the project & programme teams has grown over time as a result of having a 'can do' attitude to requests, and not having the appropriate mechanisms in place to filter/prioritise projects, which has unfortunately led to demand outstripping supply. In addition to this there are resource constraints that have been identified as contributing factors to the situation.

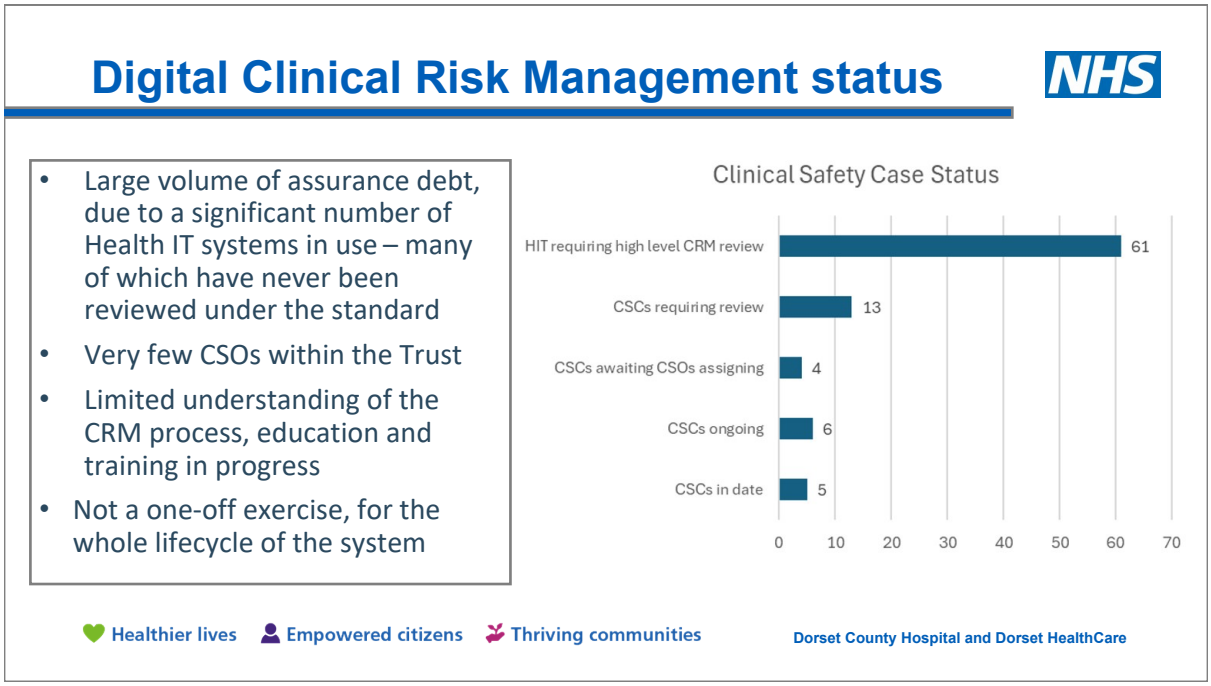
1.5. A set of actions have been identified in discussion with JEMT as part of a Digital Recovery Plan and are set out in this report.

2. Clinical Risk Management

2.1. All organisations that use health IT systems have to comply with DCB0160 standards as part of the Health and Social Care Act 2012. What this means to DCH/DHC is that for each system deployed, a clinical safety assessment has to be performed before that system is used. Where there are systems already in place, those systems need to be retrospectively assessed, and a Clinical Risk Management File established for each system.

2.2. Given the relative size of DCH and the financial constraints, there is a capacity issue around clinical risk management. There is no dedicated Clinical Safety Officer (CSO) or a Clinical Risk Management Lead for DCH. The Chief Nursing Information officer (CNIO) has had to perform the roles of CSO and clinical safety case reviewer, whilst developing the clinical risk management strategy, on top of normal CNIO duties.

2.3. The image below shows the current status of the clinical risk management backlog, with 61 Health IT (HIT) systems requiring a review.



Clinical Risk Management Backlog

2.4. In discussion with JEMT we've agreed an action that DCH Chief Nursing Information Officer (CNIO) will work closely with the divisions to identify and agree where clinical staff can be given the capacity to undertake clinical risk assessments with the CNIO and supported by the digital team.

2.5. An action has also been agreed for the DCH CNIO to work with DHC colleagues (deputy CNIO and CMIO) to develop a joint priority list for both organisations and to align on the approach to clinical risk management of Health IT systems.

3. Project Reprioritisation

3.1. It has been acknowledged that it isn't possible to meet the current demand for digital projects, or projects that require digital input, due to the build up of the number of requests.

3.2. Requests can come in the form of national initiatives, improvement projects, the ongoing maintenance or upgrade of existing systems, and risk mitigation activities that have been identified as requiring to be carried out across the digital system/application estate.

3.3. A reprioritisation exercise was recently undertaken by the Digital projects and programmes team to identify and recommend the most urgent priorities and was presented to a group of senior leaders and executives on 12 February 2025. A further meeting took place on 17 March 2025 to confirm the priorities with DCH COO and divisional directors. The next steps are to provide an update to the next DCH SLG in March.

3.4. A risk-based approach was taken to assess and score the projects in order to develop the priority list, with an understanding of the risks associated with not proceeding with certain projects. Resource constraints, specifically around the

clinical systems support team (CSST) and clinical risk assessments, means that its not possible to run multiple concurrent projects and hence the need to agree which projects to pause, deprioritise, and which to continue with.

3.5. **Vitals**: One of the priority projects which have been agreed is for the Vitals upgrade. Vitals is a software system used for e-observations of patients and bedside assessments, and for the calculation of early warning scores. DCH are currently four versions behind in terms of the software and needs to be upgraded as a matter of urgency.

3.6. This upgrade will be a significant undertaking and will involve developing a detailed plan with the supplier and clinical colleagues. The upgrade itself will need to be thoroughly tested and the interface will have significant differences, meaning that clinical staff will have to undergo training before the upgrade is deployed.

3.7. **Critical Care**: With the impending new Critical Care Unit as part of the New Hospitals Programme (NHP), one of the deliverables is to deploy a new clinical information system. There are factors that will influence the decision to go ahead with this project, resources being one of them, as the Vitals upgrade has been agreed to take precedence from a patient safety perspective and will need the subject matter experts and clinical systems support team to focus on Vitals.

3.8. The other factors to take into consideration are the timelines for procurement of a clinical information system, as the new EHR programme and the capabilities this will deliver will supersede the need for the system. The procurement for EHR is expected to commence in late May to early June this year. In summary, as the timelines are shortening, the opportunity to go to market then implement and use a clinical information system are diminishing as it will have a limited use before being replaced by the new EHR.

3.9. A short paper is being prepared to consider the options for this and will be brought back to JEMT in the next 1-2 weeks for discussion.

3.10. **Going forward**: the digital projects and programme team will form a sub-group of the relevant stakeholders across the divisions to ensure there is strong engagement and discussion around the prioritised projects in terms of progress, and to provide the forum for agreement on future priorities for digital projects. This sub-group will then bring forward any decisions for ratification at the Digital Transformation & Assurance Group, and onward to STP CiC.

Governance of projects and recovery activity

3.11. In addition to the monthly sub-group, there is a bi-weekly meeting with the Chief STP Officer to review the activities and actions associated with the digital recovery plan.

4. Recovery plan activities

4.1. A number of activities have been identified which will help with beginning to address the historical issues and the previously mentioned backlogs. Activities will be reviewed every two weeks as part of the DCH digital recovery plan.

Issue to address	Governance & management of projects	Relationship management & prioritisation	Clinical Risk Management backlog	Clinical Safety Officer resource	Ownership & Control of clinical systems and applications
Improvement activity	Implementation of more efficient and effective controls for the management of projects to avoid accepting projects without acceptance criteria.	Better integration between digital teams and Divisional, Operational teams to inform planning and prioritisation that reflect the business needs.	Baseline existing systems in preparation for CRM assurance debt review. DCH & DHC digital clinical teams will work together to develop and agree a joint priority list for the backlog of systems requiring an assessment.	Grow the number of trained Clinical Safety Officers, particularly in DCH, that can assist with the backlog and for any new system implementations or changes. Agree with divisional directors to free up capacity for clinical colleagues to assist.	Conduct a full inventory of all clinical applications in use across the trust including contract terms, software version, how and who administers, no. of users. This will address any 'shadow IT' and bring all systems under control.
Timelines	Q1	Q1	Q1 & Q2	Q1 through Q4	Q1 through Q4

Issues to address and related improvement activities

5. Resources

5.1. In discussion with the JEMT, support was given to proceed with three roles that are needed to help with the recovery plan activities. Those roles in particular are already within the agreed establishment and will be supported in going through the DCH Recruitment Control Panel (RCP).

5.2. In addition, consideration needs to be given to developing a business case for bringing in additional capacity for the Clinical Systems Support Team (CSST) who are the most constrained of all in terms of delivery of projects and management of system upgrades.

6. Conclusion

6.1. The previous Digital Capacity & Capability report which was brought to STP CiC in January highlighted a number of issues with the historical build up of backlogs for clinical risk management and the number of projects that have grown to an unmanageable situation.

6.2. The DCH CNIO will work with divisional colleagues to identify and agree where clinical colleagues can be allocated capacity to assist with clinical risk assessments of DCH digital systems, whilst growing the CSO community through training.

6.3. The immediate reprioritisation activities in collaboration with executives and divisional colleagues will help to agree which projects need to be prioritised.

6.4. Implementing a regular forum to allow divisional colleagues the opportunity to engage and agree on the future priorities going forward will ensure a clear understanding of which projects can be delivered and when, and subsequently will enable better demand management within the capacity constraints.

6.5. Support has been given to proceed with a number of roles through Recruitment Control Panel for those roles already within the establishment (and budget).

7. Recommendations

7.1. The Board / Committee is recommended to:

a. Receive the report for **information.**

b. Receive the report for **assurance.**

Name and Title of Author:
Stephen Docherty, interim Chief Digital Information Officer

Date 19 March 2025

Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report
for the meeting held on 27 March 2025

Chair	Stuart Parsons
Executive Lead	Chris Hearn, Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Recommendation that the accounts are prepared on a Going Concern position • Approval of Financial Statements (Review of Accounting Policies Areas of Estimation) • Recommendation for the approval of the Standing Orders for the Board

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Going Concern Statement, with a recommendation that the accounts are prepared on a going concern basis, recognising the commitment across the Dorset system to continue providing healthcare.
	• Financial Statements (Review of Accounting Policies Areas of Estimation), noting no significant changes to the policies. The main area of estimation continues to be the valuation of properties. Non-consolidation of charitable funds. Consolidation of subsidiary company funds. This is in line with previous years.
	• Internal Audit Plan for 2025/26 noting the plan has been developed following a review of the Board Assurance Framework and in discussion with executives. Some of the audits are aligned with audits at DHC and flexibility in the plan to focus on additional areas as needed.
	• Internal Audit progress reports, noting:
	  ○ Receipt of comments from the ICB on the system operating model governance audit report.
	  ○ The joint strategy report returned moderate assurance on design and moderate assurance on effectiveness.
	  ○ The pressure on teams and risk to the ability to respond to audit actions was noted.
	• External Audit Value for Money Risk Assessment, noting no risks of significant weakness identified in relation to governance or improving economy, efficiency and effectiveness, but a risk of significant weakness identified in relation to financial sustainability.
	• Counter Fraud Progress Report and Workplan 2025/26

	• Managing Conflicts of Interest Policy noting alignment with Dorset Healthcare, and in line with the national policy. All staff who are band 8d or above are considered decision makers and will need to declare any interests (including a nil return) on an annual basis. All staff who have a conflict to declare are required to make a declaration. The process for declaring conflicts of interest will be relaunched to staff in the trust. • Annual Report Timetable • Freedom to Speak Up and Whistleblowing Arrangements noting assurance around the arrangements in place for staff to raise concerns. • Standing Orders for the Board noting work to update the constitution and standing orders following changes in national guidance and to align with Dorset HealthCare.
Decisions made at the meeting	• Recommendation for the approval of the Going Concern Statement • Approval of Financial Statements (Review of Accounting Policies Areas of Estimation) • Approval of the Internal Audit Plan for 2025/26 • Approval of the Counter Fraud Plan for 2025/26 • Approval of the Managing Conflicts of Interest Policy • Approval of the Annual Report Timetable • Recommendation for the approval of the Standing Orders for the Board
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance					
	18/06/2024	**17/09/2024**	**17/12/2024**	**03/02/2025**	**27/03/2025**
Quorate?	Y	Y	Y	Y	Y
Stuart Parsons	Y	Y	Y	Y	Y
Claire Lehman	Y	Y	Y	Y	A
Stephen Tilton	Y	Y	Y	Y	Y
Dave Underwood	Y	Y	Y	Y	A

Report to	**Board of Directors**	
Date of Meeting	8th April 2025	
Report Title	**Going Concern Review**	
Prepared By	Mark Lovett, Financial Controller	
Approved by Accountable Executive	Chris Hearn, Joint Chief Financial Officer	
Previously Considered By	Audit Committee	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? Delete as required	
Care		No
Colleagues		No
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6: Finance – the review of going concern is required each year to ensure compliance with accounting standards and company law and must also be compliant with the additional requirements contained in the Department of Health and Social Care Group Accounting Manual (GAM).	
Financial	The review is to ensure the financial sustainability of the Trust and requires a realistic assessment of whether the going concern basis is appropriate.	
Statutory & Regulatory	To comply with the terms of the Trust's authorization	
Equality, Diversity & Inclusion	Not applicable	
Co-production & Partnership	Not applicable	

Executive Summary

When preparing financial statements, management are required to make an assessment of the Trust's ability to continue as a going concern. The Trust shall prepare financial statements on a going concern basis unless management either intends to liquidate the entity or to cease trading, or has no realistic alternative but to do so.

This papers reviews the information and data available to carry out this assessment, addressing the commission of ongoing service provision and assessment of the Trusts ability to continue with the financial resources available.

For 2025-26 the Trust continues to be commissioned to provide Healthcare services by the Regulator and continues as a Provider within the Dorset Integrated Care System. As a result, the Trust has no plans to discontinue any operations, transfer core services or significantly amend its structure.

The Trust is forecasting a 2024-25 breakeven position with a cash balance of £9.2m at the end of March 2025. While current planning indicates a 2025-26 and 2026-27 deficit position, discussions are ongoing to work through the details and aim to improve the position. At this stage, indications are that cash support will be required to support the revenue pressures in 2025-26. The Trust has received significant support in year from both the System and Region to alleviate revenue pressures and due to continued service provision requirements in 2025/26 this support will be continued in future years.

With this in mind, plus ongoing requirements to operate as a collaboration within the ICB it is reasonable to assume the financial resources of the Trust include those available to the wider System, which

include significant cash balances.

Finally, as per guidance issued by Department of Health and Social Care Group; “The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.”

As a result, and upon agreement from the Audit Committee and Board, the assessment evidences the Trust’s ability to continue and meets the requirements to present accounts on a going concern basis and a statement to this effect will be included in the Annual Report and Accounts (draft detailed in section 5 of attached report).

Recommendation

The Board is recommended to:

1. Review the draft assessment of going concern and
2. If satisfied with assessment, approval.

GOING CONCERN BASIS FOR ACCOUNTS PREPARATION

1. INTRODUCTION

1.2 All Foundation Trusts are required to prepare their annual accounts in accordance with accounting standards and company law, and must also be compliant with the additional requirements contained in the Department of Health and Social Care Group Accounting Manual 2024-25 (GAM).

1.3 To comply with accounting standards, management are required to make as assessment of the Trust's ability to continue as a going concern. For Foundation Trust's the GAM goes on to detail that the financial statements should be prepared on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

1.4 This includes the concept of the accounts being prepared on the basis that the entity is a going concern and is expected to continue its business operations for the foreseeable future. A key consideration of going concern is that the Trust has sufficient financial resources to meet its obligations as they fall due.

1.5 The purpose of this paper is to provide information and assurance to the Trust Board that the Trust can consider itself a going concern. The Trust Board are asked to review and confirm that they consider the Trust to be a going concern.

2. REQUIREMENTS

2.1 Directors must assess each year whether it is appropriate for the Trust to prepare its accounts on the going concern basis, considering best estimates of future activity and considering any significant doubt on the Trust's ability to continue.

2.2 The Department of Health and Social Care Group Accounting Manual 2024-25 (GAM) reminds NHS Foundation Trusts; "The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

2.3 The Trust should include a statement on whether or not the financial statements have been prepared on a going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary (*Code of Governance D.2.9*).

2.4 Where there is a material uncertainty over the going concern basis (for instance, continuing operational stability depends on finance or income that has not yet been approved), or where the going concern basis is not appropriate, the directors will need to disclose the relevant circumstances and should discuss the basis of accounting and the disclosures to be made with their auditors.

3. TRUST ASSESSMENT

3.1 Future activity assessment

For 2025-26 the Trust continues to be commissioned to provide Healthcare services by NHS England and continues as a Provider within the Dorset Integrated Care System.

3.2 All communications from regulators detail continuation of existing service provision, and while a handful of service Transfers are under consideration within the System, no notifications have been received to cease core activity. As a result, the Trust has no plans to discontinue any operations, transfer core services or significantly amend its structure.

3.3 The Trust is in the process of setting up contracts with its local commissioners with services being commissioned in the same manner as in previous years.

3.4 Assessment on significant doubt

To gain assurance that there is no significant doubt for the Trust to continue, management need to review all available information about the foreseeable future, deemed to be a minimum of 12 months from the end of the reporting period. This review should consider the future forecasts and financial resources available to the Trust to determine whether significant doubt exists.

3.5 The Forecast financial outturn indicates that the net Income and Expenditure outcome for 2024-25 is a breakeven position and closing cash position of £9.2m.

3.6 While Trust's current medium-term plan has a deficit of £40.0m for 2025-26 with a borrowing requirement of £30.5m, these figures represent the current position and form part of on-going discussion around the contracts for 2025-26, the Trust expects movement in these figures between now and the final planning submission for 2025-26. The plan also includes a financial deficit in 2026-27 of £26.1m.

3.7 The Trust's cash position for 2024-25 and forecast cash flow up until Q1 2026-27 is as follows:

	Forecast 2024-25	Plan 2025-26	Plan Q1 2026-27
Surplus (Deficit) from Operations	**4,947**	**(34,533)**	**(5,158)**
Non-cash or non-operating income and expense	8,918	11,904	2,976
Net cash inflow/(outflow) from operating activities	**13,865**	**(22,629)**	**(2,182)**
Investing activities	(18,471)	(36,365)	(10,390)
Net cash inflow/(outflow) from investing activities	**(4,606)**	**(58,994)**	**(12,572)**
Financing activities	4,997	50,798	12,572
Net cash inflow/(outflow) from financing activities	**391**	**(8,196)**	**0**
Opening cash and cash equivalents less bank overdraft	8,805	9,196	1,000
Net cash increase / (decrease)	391	(8,196)	0
Closing cash and cash equivalents less bank overdraft	**9,196**	**1,000**	**1,000**

3.8 While, at this stage of planning, the Trust is forecasting deficits over the next 2 years, the Trust has been and will continue to be supported from both a System and Regional

perspective. The Trust has received significant support in year to alleviate revenue pressures and due to continued service provision requirements in 2025/26 this support will be continued in future years.

3.9 With this in mind, plus ongoing requirements to operate as a united group within the ICB it is reasonable to assume the financial resources of the Trust include those available to the wider System, which include significant cash balances.

3.10 The Trust has an outstanding capital loan of £4.6 million from the Foundation Trust Finance Facility (FTFF), which is due to be repaid in March 2026. The Trust has contacted the NHS cash team to look at an extension on the loan term for the Foundation Trust Financing Facility (FTFF) including a phased repayment plan.

4. CONCLUSION

4.1 The Income & Expenditure Forecast for 2024-25 is a break-even position and the closing cash position of £9.2m.

4.2 The Medium-term financial plan for 2025-26 is a deficit of £40.0m, however planning conversations continue with expectations that this position will improve before the final iteration is reached.

4.3 The Cash flow forecast shows the need for cash support during 2025-26 to maintain liquidity, as evidenced by requirements this has been made available in 2024-25 from both System and Regional cash input and will continue if necessary in 2025-26.

4.4 The Trust will have contracts with national and local commissioners for 2025-26 and the Board of Directors have made no decisions to discontinue any operations, transfer services or significantly re-structure the organisation.

4.5 The regulator (NHSE) have not issued any communications that impact on our going concern assessment.

4.6 Given the continued requirements for the Healthcare services and available revenue support, it is concluded that the Foundation Trust has no material uncertainty that financial resources are available to the Trust to continue service provision for the foreseeable future.

4.7 The Trust therefore meets the requirements of Department of Health and Social Care Group Accounting Manual 2024-25 as there is evidence of provision of a service in the future, and therefore it is appropriate that it prepares its accounts on a going concern basis and includes a statement to this effect in its Annual Report and Accounts.

5. GOING CONCERN – STATEMENT FOR THE 2024-25 ANNUAL REPORT AND ACCOUNTS

5.1 Based on the above conclusion, it is proposed to include the following statement in the Annual Report and as a note in the Annual Accounts, as required by the Department of Health and Social Care Group Accounting Manual (GAM) 2024-25:

"International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be

prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

(The figures in the paragraph are based on the table above and will be updated for actual outturn and the final plan when information is available)
The Trust is reporting a breakeven position for the year ended 31 March 2025. As at 31st March the Trust had a closing cash position of £9.2 million. The Trust has submitted a planned deficit of £40.0m for 2025/26 and a closing cash position of £1.0 million. The Trust's plan includes interim cash support of £30.5 million in 2025/26. Similar projections are anticipated during the 1st quarter of 2026/27.

The directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual."

6. ACTION REQUIRED BY THE BOARD

6.1 The Board is requested to:

a) receive this report on the going concern assessment undertaken;

b) note the impact on the going concern position of the Trust;

c) consider whether the Board accepts and agrees with the conclusion reached by the author;

d) if so, to resolve that the annual accounts for the year ended 31 March 2025 should be prepared on a going concern basis.

Mark Lovett
Financial Controller
February 2025

Dorset County Hospital
NHS Foundation Trust

DCH Charitable Funds Committee Assurance Report for the meeting held on 18.3.2025

Chair	Dave Underwood
Executive Lead	Nicholas Johnson
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• **DCH Charity Business 25/26** – Committee noted the DCH Charity Business Plan 25/26 has been approved by DCH Board (Corporate Trustee)
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (20.1.25)** – minor amend noted, then approved as an accurate record. • **CFC Actions (20.1.25)** – All actions completed or in progress. • **DCH Charity Business 25/26** – Committee noted the DCH Charity Business Plan 25/26 has been approved by DCH Board (Corporate Trustee) • **DCH Charity Financial Reports 24/25 (M11)** – reports were received. Total income as of end Feb 2025 £528,354 (plus additional £53,713 legacy income received in 24/25 (accounted for in 23/24 accounts as notified in 23/24). Major legacy receipt still pending, now expected 25/26. Unrestricted funds were £307,463 providing a surplus of £67,463 against the reserves target of £240,000. • **£2.5M Capital Appeal (ED/CrCU) report (Feb 2025)** – £546K income and pledges received to date. • **Fundraising & Communications report** – overview of current key fundraising activities and communications. • **Innovation Fund (new)**: committee agreed to receive a paper from MB at next meeting outlining the objectives/framework for an Innovation Fund. • **Lillian Martin legacy:** sale of land (£250K), expected completion end Mar 2025. Six beneficiaries, DCHC share c.£33K (minus costs).
Decisions made at the meeting	• None

Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	Date 19.11.24	Date 20.1.25	Date 18.3.25			
Quorate?	Y	Y	Y			
Dave Underwood	Y	Y	Y			
Chris Hearn	Y	Y	N			
Jo Howarth	Y	Y	N			
Anita Thomas	Y	Y	Y			
Margaret Blankson	Y	Y	Y			
Stephen Tilton	Y	N	Y			

Report to	Board of Directors	
Date of Meeting	8th April 2025	
Report Title	Trust Constitution 2025 Review and Update	
Prepared By	Claire Lea, Director, Charis Consultants Limited	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	Council of Governors Constitutional Review Working Group – 25th November 2024, 16th January 2025 (both held jointly with the DHC working group) and a final Trust only session on 21st January 2025 DCH Council of Governors 3rd March 2025	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	No implications	
Financial	No implication.	
Statutory & Regulatory	An up-to-date Constitution that reflects the system working expectations of the Health and Care Act 2022 (2022 Act) and the NHS Providers Code of Governance (2022 Code) provides a solid foundation for up-to-date governance arrangements in line with current requirements.	
Equality, Diversity & Inclusion	The Trust's commitment to EDI is strengthened by an up-to-date Constitution which upholds the best practice principles of governance	
Co-production & Partnership	The Constitution is required to be approved jointly by the Board and the Council. Governors have been directly involved in the production of the revised Constitution. There are clear expectations and frameworks within the document that support working in partnership and co-production.	

Executive Summary

The Board of Directors is being asked to approve the changes to the Constitution and Annexes set out in the report. The draft submitted has already been approved by the Council of Governors.

The paper sets out the recommended changes to the Trust's Constitution and associated Annexes. The changes will bring the document in to line with latest legislative requirements and best practice governance. The intention has also been to align the Constitution with that of Dorset HealthCare University NHS Foundation Trust (DHC) to further support the commitment between the two organisations to joint working and collaboration.

Charis Consultants Limited and its director, Claire Lea, was commissioned to undertake the review to add additional capacity to the corporate governance team. Claire has worked with both Councils previously in their induction and development training.

The review work has considered the Constitutions of both Trusts and then compared them against one of the most recently updated Constitutions available in the public domain. Liverpool University Hospitals NHS Foundation Trust (Liverpool) updated their constitution in October 2024, and they have committed to working jointly with Liverpool Women's Hospital NHS Foundation Trust in a group model. This means their October 2024 Constitution has been updated to reflect joint working arrangements and the making of joint board appointments.

The review identified a lot of minor discrepancies between the two documents and also a considerable difference in the layout of the material and style of presentation. To address this, both Trusts have taken a fresh approach and now follow the format set out by Liverpool. This provides an aligned document for both Trusts which will help the Board, Council and the governance team.

To achieve this using a tracked changes approach on each existing Constitution would have made for an untenable document for the Board and Council to so consider, so the Liverpool document has been as the base template. Behind this, there is a full breakdown of the alignment checks that have been carried out to ensure an audit trail in table form which lists every single change from the original constitution. Orphan material which has been removed from the Constitution, has been saved so that it can be added to the induction material provided to new Governors.

The full breakdown of the alignment checks has been worked through with the Council's Constitutional Review Working Group and the resulting changes are recommended with the support and agreement of the Working Group.

Specific to this Trust, the current Constitution and Annexes did not include an Annex covering Additional provisions – Board of Directors, however, much of the appropriate content was elsewhere within the original. Consequently, Annex 5 has been created and included within the revised document.

The most significant change has been the realignment of the public constituency boundaries in line with the parliamentary boundary changes from 2023 and the recommendation to amalgamate the resulting West and South constituencies as well as the North and East Constituencies. This is recommended to alleviate the level of vacancies in some of the current public constituencies. Further detail is provided below in the rationale for change set out in the table for Annex 1.

The other major area for discussion concerned the eligibility of Staff Governors for the Lead Governor role. The Working Group discussed this at some length weighing the equitable treatment of all governors against potential conflicts of interest and maintaining the independence of the Lead Governor role. This was also a major area of discussion for DHC who on balance agreed to maintain the ineligibility of Staff Governors to stand as Lead Governor. The DCH Council affirmed their support for a similar position and so the recommendation to the Board is aligned to this position.

There has also been discussion relating to the removal of a seat at Council for an Appointed Governor representing the Integrated Care Board. As set out in Annex 3 this has been reallocated to the Partner Organisations by increasing the number of national/regional health care seats from 3 to 4. The recommendation goes further that one of these four seats should be allocated to a partner organisation who could ensure learning disability and autism representation at the Council.

The Working Group also made suggestions as to the partner organisations who might fill the remaining 3 seats to provide a greater range of diverse voices being heard at Council. These included Healthwatch, Marie Curie, St Johns Ambulance, Maternity Voices and Youth Voice. There is no requirement to decide on these partner organisation in order to approve the Constitution and Annexes, but there should be an action listed for future Council and Board meetings to discuss and agree which organisations should be invited to be partner organisations (i.e. willing to appoint a representative to act as Appointed Governors).

The revision has also included updating and aligning the Standing Orders for the Board of Directors. These are included within Annex 7 and require approval by the Audit Committee and Board as required by the Constitution.

The current Constitution requires any proposed additions and/or amendments to the Constitution and Annexes to be presented first to the Board of Directors for approval and subsequently to the Council of Governors. On this occasion given the extensive work of the Council's Constitutional Review Working Group the amendments were presented to the Council first. The Board of Directors is asked to approve the reversal of the approval order on this occasion.

The Council of Governors require a quoracy of 2/3 of all Governors including vacancies present (19 required) and more than half voting in favour. At this time we only have 16 Governors in post and so do not have the required level of quoracy to approve the standing orders. At the Council of Governors meeting on 3rd March 10 Governors were present and all voted in favour. We planning to commence an election process and so will submit the Standing Orders for approval once we have at least 19 Governors in post.

The changes outlined in the Constitution fall into three categories :-
Yellow highlighted text – is required as the content was missing or inaccurate in the current version
Turquoise highlighted text – is required due to recent legislation e.g creation of integrated care systems
Green highlighted text – recommended for alignment with DCH

The significant changes and their rationale are set out in the report.

Recommendation

Members are requested to:

- **Approve** the reversal of the approval process for changes to the Constitution, accepting that they have been approved by the Council prior to submission to the Board.
- **Approve** the Constitution and its Annexes including specifically Annex 7 – Standing Orders for the Board of Directors.
- **Note** that final approval of the Standing Orders cannot take place until at least 19 Governors are in post, but that they can be approved by the Board at this stage.
- **Agree** the creation of an action point for future Council and Board meetings to discuss and agree who should be invited to be partner organisations (i.e. willing to appoint a representative to act as Appointed Governors).

Trust Constitution 2025 Review and Update

Executive Summary

The paper sets out the recommended changes to the Trust's Constitution and associated Annexes. The changes will bring the document in to line with latest legislative requirements and best practice governance.

The intention has also been to align the Constitution with that of Dorset Healthcare University NHS Foundation Trust (DHC) to further support the commitment between the two organisations to joint working and collaboration.

The review work has considered the Constitutions of both Trusts and then compared them against one of the most recently updated Constitutions available in the public domain. Liverpool University Hospitals NHS Foundation Trust (Liverpool) updated their constitution in October 2024, and they have committed to working jointly with Liverpool Women's Hospital NHS Foundation Trust in a group model. This means their October 2024 Constitution has been updated to reflect joint working arrangements and the making of joint board appointments.

Specific to this Trust, the current Constitution and Annexes did not include an Annex covering Additional provisions – Board of Directors, however, much of the appropriate content was elsewhere within the original. Consequently, Annex 5 has been created and included within the revised document.

Orphan material which has been removed from the Constitution, has been saved so that it can be added to the induction material provided to new Governors.

The most significant change has been the realignment of the public constituency boundaries in line with the parliamentary boundary changes from 2023 and the recommendation to amalgamate the resulting West and South constituencies as well as the North and East Constituencies. This is recommended to alleviate the level of vacancies in some of the current public constituencies. Further detail is provided below in the rationale for change set out in the table for Annex 1.

The other major area for discussion concerned the eligibility of Staff Governors for the Lead Governor role. The Working Group discussed this at some length weighing the equitable treatment of all governors against potential conflicts of interest and maintaining the independence of the Lead Governor role. This was also a major area of discussion for DHC who on balance agreed to maintain the ineligibility of Staff Governors to stand as Lead Governor. The recommendation for DCH is aligned to this position.

There has also been discussion relating to the removal of a seat at Council for an Appointed Governor representing the Integrated Care Board. As set out in Annex 3 this has been reallocated to the Partner Organisations by increasing the number of national/regional health care seats from 3 to 4. The recommendation goes further that one of these four seats should be allocated to a partner organisation who could ensure learning disability and autism representation at the Council.

The Working Group also made suggestions as to the partner organisations who might fill the remaining 3 seats to provide a greater range of diverse voices being heard at Council. These included Healthwatch, Marie Curie, St Johns Ambulance, Maternity Voices and Youth Voice. There is no requirement to decide on these partner organisation in order to approve the Constitution and Annexes, but there should be an action listed for a future Council meeting to discuss and agree who should be invited to be partner organisations (i.e. willing to appoint a representative to act as Appointed Governors).

The revision has also included updating and aligning the Standing Orders for the Board of Directors. These did not require Council approval, but do require Board approval. These are included within Annex 7 and require approval by the Audit Committee and Board as required by the Constitution.

The changes outlined in the Constitution fall into three categories :-

Yellow highlighted text – is required as the content was missing or inaccurate in the current version
Turquoise highlighted text – is required due to recent legislation e.g creation of integrated care systems
Green highlighted text – recommended for alignment with DCH

The full breakdown of the alignment checks has been worked through with the Council's Constitutional Review Working Group and the resulting recommended changes were approved by the Council of Governors on 3rd March 2025

1. Introduction

1.1. The constitution is one of the most important documents within any foundation trust and all foundation trusts are required to have one

1.2. A foundation trust's constitution contains detailed information about how that foundation trust will operate. It sets out, for example, the foundation trust's membership area, gives information on the various membership constituencies, and determines the size and composition of the board of directors and the council of governors. It also prescribes the rules by which any election to the council of governors is to be conducted.

1.3. Having clear rules about how the organisation operates offers assurance to patients and service users that the governance of the foundation trust is sound.

1.4. There is a model foundation trust constitution prescribed by legislation which requires certain aspects of the constitution to be in place, other aspects are left to the Board of Directors and Council of Governors to agree locally.

1.5. Any amendments to the constitution require the approval by majority vote of both the board of directors and the council of governors so it is vital that governors are satisfied that they understand what it is that they are being asked to approve.

1.6. Foundation trusts are required, both in law and as part of their provider licence, to inform the regulator of the changes but it has no role in determining whether the constitution is legally compliant.

1.7. Once the board and council have approved the changes, they take immediate effect. The revised constitution should then be circulated to all directors and governors for information, and a copy sent to the regulator within 28 days of approval (this is the later of the two dates on which the board and council approved the changes). Copies on the foundation trust's website should also be updated.

2. The rationale for change

Constitution – Paragraph	Rationale for change
4.1 and 4.6 – 4.14	The 2022 Act sets out the statutory duties for system working. These changes reflect the changes brought in by the Act and in particular provide for joint working
4.4 & 4.5	The powers in relation to the Mental Health Act were missing from the current version and are set out here to address that gap.
4.6 – 4.13	Provisions relating to joint working as required by the 2022 Act were missing and these have now been added.
5.2	The Secretary's responsibility to decide on eligibility for constituency membership was missing in the current version and this addresses that gap
8.3.1	Confirming that seconded staff would meet the staff threshold for the staff constituency to align with DHC.
8.9	Current provision allowed staff to opt out of staff membership and elect to be public members has been removed. This poses a conflict of interest and has been removed.
10.2	Provision reinforcing that staff can only apply to be staff governors as per 8.9 above.
12.4	Removal of provision for an appointed governor to represent the ICB due to the agreed conflict of interest. See later in Annex 3 for overall changes to composition.
13.1	Provision added to clarify it is the Board's decision as to which voting method is used based on the Model Election Rules. This aligns the election process with DHC.
13.2 & 13.3	This updates the clause for Election Rules to include NHS Providers and that changes therein do not lead to a change in the Constitution.
14.2	Clarifies that moving house into a new constituency would be grounds for ceasing to hold office as an elected governor.
14.4	Clarifies start of tenure for appointed governor to align with elected governors.
14.7	The provision of a 1 year break in the calculation of consecutive years of office for elected and appointed governors was missing from the current version.
15.1.5	Governors must be 16 years of age as aligned to DHC. Previously was 18 for DCH.
17.1	The DCH Constitution provides the Chair with a casting vote at Council meetings. The current version allows for the Lead Governor to chair the Council meeting which is not in line with good practice (Code 2022) and this has been removed.

	The Working Group recommended that the alignment and removal.
19.1-19.3	The Monitor Panel for governors is no longer in existence and should not be included. Para to be removed with all subsequent numbering adjusted and cross referenced.
23.2	Changes to Board composition provide a numerical range for Executive (EDs) and Non-Executive Directors (NEDs) in line with current numbers appointed and to provide flexibility going forward.
23.8, 23.9	Clarification of the role of Associate NEDs and non-voting EDs on the Board was missing in the current version.
24.1	Statement of the general duty of the Board was missing from the current version.
27.2	The DCH Constitution already provided for the Board appointment of a SID in consultation with Council. Clarity of the role was missing from the current version.
30.2	The statutory requirement to send a copy of the Board meeting agenda to CoG was missing from the current version.
31.1	Alignment of process for varying and amending BoD's Standing Orders with para 12.3 of the Constitution and 4.42 of Annex 7 was missing from the current version.
33.3	The Code 2022 specifies the composition of the Nominations and Remuneration Committee for the Council of Governors, as well as the tenure for NEDs.
37.2	A full list of the documents available for public inspection is missing in the current version. This is corrected here.
38.3	The clause relating to the Auditor was missing in the current version and these changes address that gap
38.5	Removal of approval by Council of the Board resolving to carry out additional services. This is the role of the Audit Committee.
39.1 and 39.2	The Code 2022 specifies membership and chairing of the Audit Committee
40.6	Responsibilities of the Accounting Officer was missing in the current version and these changes address that gap
45.3 – 45.6	Definition of significant transaction increased from 20% to 25% and mirrored by DHC. Also the Code 2022 requires a written statement of reasons if approval is denied and this is missing in the current version.

Annex 1 -	Public Constituency
	There is a recommended re-structure of constituencies to address hard to recruit to constituencies in the current structure. The recommendation is to move from five public constituencies to three. This would create an amalgamated West and South Public Constituency with 11 seats on Council) that follows the new parliamentary boundaries (i.e. including Weymouth and Portland) and would also include 3 electoral wards from the Mid Dorset and North Poole parliamentary constituency. The recommendation also includes creating an amalgamated North and East Public Constituency (with 4 seats on Council) that also follows the new parliamentary boundaries (i.e. including Puddletown & Lower Winterborne electoral wards) and would also include 7 electoral wards from the Mid Dorset and North Poole and old East Dorset parliamentary constituencies) The third public constituency of South Somerset and Rest of England remains unchanged. The recommendation is based on the footprint of the community served by DCH as the main provider of acute hospital services to a population of around 300,000, living within Weymouth and Portland, the west and north of Dorset, and Purbeck. DCH also provides renal services for patients throughout Dorset and South Somerset; a total population of 850,000. The allocation of seats to the two recommended revised public constituencies also seeks to mirror the population and electorate numbers in the parliamentary constituencies across the county.

Annex 3 -	Composition of Council of Governors
	The requirement for a majority of public governors was missing in the current version although true in practice. The Working Group discussed and recommended that the organisations represented by the Appointed Governors should be reviewed and the appointed governor for the ICB should be reallocated to a partnership organisation to provide for a learning disability and autism representative (organisation tbc). There were also discussions about other partner organisations that may be approached – these included: Healthwatch Marie Curie St Johns Ambulance Maternity Voices Youth Voice The table also summarises the changes to the public constituencies. There is no requirement to change the number of public governors to maintain the majority requirement above. This would maintain the total of 28 governors.

Annex 4 – paragraph	Additional Provisions – Council of Governors
1	The current version provided for 28 days which is onerous when trying to encourage active membership and reduces access to voting rights. Reduced to 7 days.
2	Current version was silent on process for appointing Appointed Governors, this is addressed here.
3 & 4	Clarity on additional duties, term of office and re-appointed for Lead Governor as this was missing from the current version.
5.1	Restriction on governors from other trusts being able to stand as a governor has been removed to help address recruitment challenges.
5.3, 5.10, 5.11, 5.14, 5.15	Ineligibility criteria for a governor (Liverpool benchmark) were missing from the current version i.e.final written warning, relationships, company director disqualification, fit and proper person regs, Sexual Offences Act, Safeguarding Vulnerable Adults Act 2006
6.2	Clarity on failing to attend meetings was missing from the current version. Failure to attend increased to three meetings from 2.
7	Grounds for removal of governor clarified
9	Process for disqualification of governors and subsequent appeal clarified
10, 11	Process for removal of governors and subsequent appeal clarified including the DCH current provision for a Standards Committee as part of that process. This will be aligned to a SOP in this regard which will require the approval of Council in due course.
12	Change the vote needed to remove a governor from 2/3rds to a majority.
13	Eligibility to stand after disqualification or removal added in as missing in the current version.
16	Additional opportunity to offer vacancies to maximise the election results
17	Clarity on the length of tenure
18-20	Declarations added in as missing from the current version and aligned to DHC.

Annex 5 – paragraph	Additional Provisions – Board of Directors No equivalent Annex in DCH original but this amalgamates the relevant content
1	Alignment of membership strategy with NED appointments (Liverpool benchmark). This was missing in the current version.
3	Role in identifying candidates was missing from the current version.
4	Clarity of attendance of CEO at Nominations Committee was missing in the current version.
6	Appraisal requirement for NED re-appointment was missing in the current version.
7-10	Process and grounds for removal of Chair and NEDs missing in the current version.
11	Ineligibility criteria for a director (Liverpool benchmark) were missing from the current version i.e. re suspension from healthcare profession, removal from register of medical practitioners, failure to disclose an interest, Sexual Offences Act, Safeguarding Vulnerable Adults Act 2006 etc
14 -16	The Code 2022 requirement for Secretary

Annex 6 - paragraph	Standing Orders for Council of Governors
1.2	Primacy of constitution missing from the current version
2.1	Cross reference to Constitution and process for amendment missing in the current version
3.3	Appointment of SID as point of contact missing from the current version
4.1.5 (& 4.17.3)	Ability to hold virtual meetings using video or computer link added as missing in the current version.
4.1.6	Requiring an ED to attend a Council meeting missing from the current version
4.2.1	Provision to include the Secretary's right to call a council meeting missing from the current version
4.2.2	Decisions taken in good faith missing from the current version.
4.3.1	Schedule of dates, times and venues to be provided (Liverpool benchmark).
4.5	Clarity on chairing CoG meetings and conflicts included as missing from the current version. Right of a governor to chair COG has been removed as not allowed within the model constitution.
4.10	This is current custom and practice but the current version is silent. Update to support custom and practice
4.14	Clarity on process for amending Council's standing orders. This is missing in the current version. Approval changed from 2/3rds to a majority.
4.17	The Working Group recommended the quorum for Council meetings be reduced to ten governors from a third of all governors to help with quoracy due to vacancies being carried
5.1	Expands power of Council to appoint committees with governors and adds Directors and other persons
7.2, 7.5	Definition of material interests and the power to remove a governor who fails to disclose a material interest – both were missing in the current version
9.1 & 9.2	Compliance was missing Standards of business Conduct and the Standing Financial Instructions.
10.1 – 10.9	Process for resolving disputes between Board and Council was missing in the current version. This recommendation taken from the Liverpool benchmark
11	The requirement to annually review council performance was missing from the current version.

Annex 7 – paragraph	Standing Orders for Board of Directors
2.1	Reinstates the role of the Secretary in advising on the interpretation of the Standing Orders.
2.2	Includes a definition and process for the Board's handling of a petition - missing from the current version.
3.7 – 3.8	Restates independence of roles of CEO and Chair - missing in the current version.
3.14	Provides for joint appointments with other Boards - missing in the current version and is now specifically included in the new legislation.
4.3	Clarifies the recording of public meetings - missing in the current version
4.4	Clarifies the period of calling a meeting - missing in the current version.
4.10	Provides for the Board agenda to be prepared by the Chair, CEO assisted by the Secretary - missing in the current version.
4.17	Clarifies quorum in relation to acting up status - missing in the current version.
4.19	Clarity on time period for called the AMM - missing in the current version.
4.34	Clarity on provision of minutes to the CoG - missing in the current version
5.3	Provides for joint committees - missing in the current version and is now specifically included in the new legislation
6.3	Provision for committees-in-common - - missing in the current version and is now specifically included in the new legislation
6.9	Alignment on the names of Board committees
7.3 -7.4, 7.10	Inclusion of the Secretary's role in advising on conflicts - - missing in the current version and is now specifically included in the new legislation
9.11	Clarity on 'relationships' in relation to pecuniary interest – missing in current version
11.1	Chair to lead a performance review of the board annually - missing in the current version
12.3	Process for the review of Standing orders clarified in line with current NHS Code of Governance
13.1 & 13.3	Clarity on role of Secretary and Audit Committee in relation to Sealing of Documents

Annex 8 -	Further provisions relating to members
2	Responsibility of member to ensure eligibility was missing in the current version
4.7	Right of appeal for expelled members. This is missing in the current version
5.1.1	Requirement to have and to pursue a membership strategy - it is custom and practice, but the current version is silent on this.
5.2 & 5.3	Current version silent on openness and prohibiting distribution. Added to amend this.
5.6	Dispute resolution for members was missing from current version. Clarified to amend this.

Annex 9 -	Annual Members Meeting
1-16	Current version silent on current custom and practice. This is set out in Annex 9 and aligned with DHC process.

There were no changes in the content of the Annex 10 – Election Rules (prescribed by the Department of Health and Social Care).

The only major areas of difference between the two Dorset constitutions following this review would relate to the public constituencies (Annex 1) and the composition of the Council of Governors (Annex 3).

3. Conclusion

3.1. The recommended changes have been fully discussed and debated by the Council's Working Group.

3.2. The changes have been approved by the Council of Governors

3.3. Approval of these recommended changes will result in an up-to-date Constitution that is fit for purpose and will support the ongoing commitment to joint working.

4. Recommendations

The Board of Directors is asked to

- **Approve** the reversal of the approval process for changes to the Constitution, accepting that they have been approved by the Council prior to submission to the Board.
- **Approve** the Constitution and its Annexes including specifically Annex 7 – Standing Orders for the Board of Directors.
- **Note** that final approval of the Standing Orders cannot take place until at least 19 Governors are in post, but that they can be approved by the Board at this stage.
- **Agree** the creation of an action point for future Council and Board meetings to discuss and agree who should be invited to be partner organisations (i.e. willing to appoint a representative to act as Appointed Governors).

Name and Title of Author: Claire Lea, Charis Consultants Limited
Date: 7th February 2025

5. Appendices

5.1. Appendix 1 - Constitution and Annexes v1 February 2025

Dorset County Hospital NHS Foundation

Trust

(A Public Benefit Organisation)

CONSTITUTION

Code for reviewing the Constitution update in February 2025.

Yellow highlighted text – is required as it was missing or inaccurate in the current version

Turquoise highlighted text – is required due to recent legislation e.g creation of integrated care systems

Green highlighted text – recommended for alignment with DCH

Certified as a true and up-to-date copy

Signed:

Name:

Position: Joint Executive Director of Corporate Affairs

Date: February 2025

Introduction

Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the two organisations and the wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and NHS Dorset.

To support the joint working, a joint Chair and a joint Chief Executive have been appointed, together with joint Non-Executive Directors and Joint Executive Directors. In line with current legislation, both Trusts remain as individual statutory organisations with individual Constitutions. Therefore, for the purposes of this document, references to the Chair and Chief Executive, and other joint roles on the Board of Directors, will remain singular and not 'joint' or 'group'.

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Interpretation and definitions

1.1 Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022.

1.2 A reference to legislation or to a legislative provision shall be to that legislation or legislative provision as it in in force, amended or re-enacted from time to time.

1.3 Headings are for ease of reference only and are not to affect interpretation.

1.4 Words importing the singular shall import the plural and vice-versa.

1.5 "Notice" is deemed served within 24 hours if by electronic means or within 72 hours if by first class post.

1.6 In addition, in this Constitution:

the **2006 Act** is the National Health Service Act 2006;
the **2012 Act** is the Health and Social Care Act 2012;
the **2022 Act** is the Health and Care Act 2022;
the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
Annual Members' Meeting is defined in paragraph 11 of the Constitution;
Appointed Governor means an appointed representative from a key stakeholder; **Constitution** means this Constitution and all annexes to it;
Constitution means the Constitution together with its annexes
Elected Governors means the Public Governors and Staff Governors;
Executive Director means a Director appointed by the relevant Committee of the Board who is a full or part-time employee of the Trust or the holder of an executive office
Non-Executive Director means a Director appointed by the Council of Governors who is not a full or part-time employee of the Trust or the holder of an executive office
Public Governor means a public Governor elected;
Staff Governor means a staff Governor elected;
NHSE is the body corporate known as NHS England, as provided by Section 1H of the 2006 Act.
Secretary means the Company Secretary of the Trust, or any other person appointed to perform the duties of the Company Secretary, including a joint, assistant or deputy secretary;
the **Trust** is defined in paragraph 2 of the Constitution.

Name

2.1 The name of the Trust is Dorset County Hospital NHS Foundation Trust ("the Trust").

Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

3.5 The Trust may carry out research in connection with the provision of healthcare and make facilities and staff available for the purposes of education, training or research carried on by others.

Powers

4.1 The powers of the Trust are set out in the 2006 Act, updated in the Health and Social Care Act 2012 and the Health and Care Act 2022

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4.4 Subject to 4.5 and as otherwise provided by section 45 of the Mental Health Act 2007, any of these powers may be delegated to a committee of Directors or to an executive director.

4.5 The Board of Directors may authorise any three or more persons each of whom is neither:

4.5.1 an executive director of the Trust; nor

4.5.2 an employee of the Trust

to exercise powers conferred on the Trust by Section 45 of the Mental Health Act 2007.

4.6 The Trust may enter into arrangements for the carrying out, on such terms as the Trust considers appropriate, of any of its functions jointly with any other person.

4.7 The Trust may arrange for any of the functions exercisable by the Trust to be exercised by or jointly with any one or more of the following:

4.7.1 A relevant body;

4.7.2 A local authority within the meaning of section 2B of the 2006 Act;

4.7.3 A combined authority within the meaning of section 65Z5 of the 2006 Act

4.8 The Trust may also enter into arrangements to carry out the functions of another relevant body, whether jointly or otherwise.

4.9 Where a function is exercisable by the Trust jointly with one or more of the other organisations mentioned at paragraph 4.7, those organisations and the Trust may:

4.9.1 Arrange for the function to be exercised by a joint committee of theirs;

4.9.2 Arrange for the Trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund in accordance with section 65Z6 of the 2006 Act.

4.10 The Trust must exercise its functions effectively, efficiency and economically.

4.11 In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to:

4.11.1 The health and well-being of (including inequalities between) the people of England;

4.11.2 The quality of services provided to (including inequalities between benefits obtained by) individuals by or in pursuance of arrangements made by relevant bodies for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;

4.11.3 Efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

4.12 In the exercise of its functions, the Trust must have regard to its duties under section 63B of the 2006 Act (complying with targets under section 1 of the Climate Change Act 2008 and section 5 of the Environment Act 2021, and to adapt any current or predicted impacts of climate change in the most recent report under section 56 of the Climate Change Act 2008).

4.13 For the purposes of this section, “relevant body” means NHSE, an integrated care board, an NHS Trust, a NHS foundation Trust (including the Trust) or such other body as may be prescribed under section 65Z5(2). “Relevant bodies” means two or more of these organisations as the context requires.

4.14 The arrangements under this paragraph 4 shall be in accordance with:
- 4.14.1 any applicable requirements imposed by the 2006 Act or regulations made under that Act;
- 4.14.2 any applicable statutory guidance that has been issued and
- 4.14.3 otherwise on such terms as the Trust sees fit.

Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:
- 5.1.1 a public constituency; or
- 5.1.2 the staff constituency.

5.2 In the case of a dispute as to which constituency an individual is eligible to be a member, the Secretary shall determine the issue. The Secretary's decision on these matters is final.

Application for membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust. A person shall become a member of the Trust from the date that they are entered onto the Trust's register of members, subject to paragraph 7, 8 and 9 of this Constitution.

Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as the area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:
- 8.1.1 They are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- 8.1.2 They have been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals, who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 For the avoidance of doubt:-
- 8.3.1 Seconded staff. Seconded staff are individuals whose contract of employment remains with another employer, but who are seconded to and line-managed by the Trust.
- 8.3.2 Individuals who assist or provide services to the Trust on a voluntary basis do not fall within the definition of individuals who exercise functions for the purposes of the Trust and are not eligible for membership of the Staff Constituency.
- 8.3.3 Those working for a partnership organisation, based at the Trust. including staff with honorary contracts at the Trust fall within the definition of individuals who exercise functions for the purposes of the Trust.

8.4 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.5 The Staff Constituency will not be divided into classes and shall comprise individuals who are eligible for membership of the Staff Constituency.

8.6 An individual may not become a member of the Staff Constituency of the Trust pursuant to paragraph 8 if they exercise functions solely for the purposes of a hosted service of the Trust, whether or not they are employed by the Trust.

8.7 For the purposes of paragraph 8.5, a "hosted service" means a service or business that is hosted by the Trust and which operated with a degree of autonomy within the Trust. The Secretary shall maintain a list of all hosted services within the Trust.

8.8 The minimum number of members in the Staff Constituency is specified in Annex 2.

~~8.9 Employees that have opted out of membership must apply to the Trust if they wish to be reinstated as a Public Constituency member and the application will be accepted by the Trust.~~

Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency; and

9.1.2 invited by the Trust to become a member of the Staff Constituency shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

Restriction on Trust membership

10.1 An individual who is a member of a constituency may not while membership of that constituency continues, be a member of any other constituency.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 The Trust Secretary shall, in accordance with the 2006 Act and the Constitution, determine the constituency of which an individual is eligible to be a member.

10.4 An individual must be at least 16 years old to become a member of the Trust.

10.5 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8 – Further Provisions relating to Members.

Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members' Meeting are set out in Annex 9 – Annual Members' Meeting.

Council of Governors – composition

12.1 The Trust is to have a Council of Governors, which shall comprise both elected Governors and appointed Governors.

12.2 The composition of the Council of Governors is specified in Annex 3. The aggregate number of Public Governors is to be more than half the total number of Governors.

12.3 The members of the Council of Governors, other than the appointed Governors, shall be chosen by election by their constituency. The number of Governors to be elected by each constituency is specified in Annex 3.

~~12.4 At least one Governor must be appointed by an Integrated Care Board within which the Trust provides goods or services~~

Council of Governors – election of Governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules. The Board of Directors will decide which of the two voting methods set out in the Model Rules for Elections is to be used.

13.2 The Model Election Rules as published from time to time by NHS Providers form part of this Constitution. The Model Election Rules current at the date of their adoption under this Constitution are specified in Annex 10.

13.3 A subsequent variation of the Model Election Rules by NHS Providers, or any other subsequent body with authority to do so, shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 44 of the Constitution (amendment of the Constitution). For the avoidance of doubt, the Trust cannot amend the Model Rules.

13.4 An election, if contested, shall be by secret ballot.

Council of Governors - tenure

14.1 An elected Governor may hold office for a period not exceeding three years commencing from the date of the Council of Governors Meeting at which their election is announced.

14.2 An elected Governor shall cease to hold office if they cease to be a member of the constituency by which they were elected. For the avoidance of doubt, this includes a Governor moving their principal residence from one public constituency to another.

14.3 Subject to 14.7, an elected Governor shall be eligible for re-election at the end of their term.

14.4 An appointed Governor may hold office for a period not exceeding three years commencing from the Council of Governors Meeting at which their appointment is announced.

14.5 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

14.6 Subject to 14.7, an appointed Governor shall be eligible for re-appointment at the end of their term.

14.7 A Governor (whether elected or appointed) may not hold office for more than nine consecutive years, and shall not be eligible for re-election or re-appointment, whichever the case may be, if they have already held office for more than six consecutive years. For the purposes of this paragraph 14, years of office are consecutive unless there is a break of at least 1 year between them. For the avoidance of doubt, this paragraph applies to the tenure of any permutation or combination of office as an elected or appointed Governor.

Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986;

15.1.3 a person who has made a composition or arrangement with, or granted a Trust deed for, their creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

15.1.5 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.1.6 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 4. Provision for the removal of Governors is also set out in Annex 4.

Council of Governors – duties of Governors

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

16.3 Further provisions about the duties of Governors are set out in Annex 4.

Council of Governors – meetings of Governors

17.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with this Constitution) or, in their absence, the Vice Chair (appointed in accordance with the provisions of this Constitution), or, in their absence, one of the Non-Executive Directors, shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, a Non- Executive Director will chair that part of the meeting. The Chair of the meeting shall have the casting vote.

17.2 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for special reasons which may include for reasons of commercial confidentiality. The Chair may exclude members of the public from a meeting if they are interfering with or preventing the proper conduct of the meeting.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

Council of Governors – Standing Orders

18.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 6. Amendment of these Standing Orders is subject to the provisions of paragraph 4.14 in Annex 6.

~~Council of Governors – referral to the Panel~~ [this will be deleted as the Panel no longer exists and all cross referencing updated due to re-numbering]

~~19.1 In this paragraph, "the Panel" means a panel of persons appointed by NHS England to which a Governor of the Trust may refer a question as to whether the Trust has failed or is failing:~~

~~19.1.1 to act in accordance with its Constitution; or~~

~~19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.~~

~~19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.~~

~~19.3 Without prejudice to the ability of a Governor to make a referral to the Panel, the Trust must take steps to secure that Governors are able to access support and / or advice, as and where necessary, to enable them to fulfil their duties.~~

Council of Governors - conflicts of interest of Governors

20.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

Council of Governors – travel expenses

21.1 The Trust may pay travelling expenses to members of the Council of Governors at rates determined by the Trust. Other expenses, if wholly incurred to allow attendance, may be paid as determined by the Trust as follows:

21.1.1 Child care expenses actually incurred and receipted;

21.1.2 Carer expenses actually incurred and receipted;

21.1.3 The Trust will not remunerate Governors for loss of earnings.

Council of Governors – further provisions

22.1 Further provisions with respect to the Council of Governors are set out in Annex 4.

Board of Directors – composition

23.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non- Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 a Non-Executive Chair;

23.2.2 no less than five and no more than 8 other voting Non-Executive Directors; and

23.2.3 no less than five and no more than 8 voting Executive Directors,

provided that, at all times, the number of independent Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.[1]

23.3 One of the Executive Directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the Executive Directors shall be the Chief Finance Officer.

23.6 One of the Executive Directors is to be a registered medical practitioner (or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

23.8 The Board shall determine whether each Non-Executive Director is independent in character and judgment and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the non-executive director's judgment. The Board shall disclose in the annual; report each Non-Executive Director it considers to be independent.[2]

23.9 The Board may also appoint up to two Associate Non-Executive Directors and up to two non-voting Executive Directors to support the Board succession strategy, diversity and achieving a balance of Board level skills. Such Directors cannot participate in any formal vote at Board.

Board of Directors – general duty

24.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Board of Directors – qualification for appointment as a Non-Executive Director

25.1 A person may be appointed as a Non-Executive Director only if:

25.1.1 They are a member of a Public Constituency; or

25.1.2 where any of the Trust's Hospital includes a medical or dental school provided by a university, they exercise functions for the purposes of that university; and

25.1.3 They are not disqualified by virtue of paragraph 29 below.

[1] Code of Governance B.2.7

[2] Code of Governance B.2.6

Board of Directors – appointment and removal of Chair and other Non-Executive Directors[3]

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint, reappoint or remove the Chair of the Trust and the other Non-Executive Directors.

26.2 Removal of the Chair or another Non-Executive Director shall require the approval of three- quarters of the members of the Council of Governors.

26.3 The Council of Governors shall adopt a procedure for appointing/removing the Chair and/or other Non-Executive Directors in accordance with any guidance issued by NHS England.

Board of Directors – appointment of Vice Chair and Senior Independent Director

27.1 The Council of Governors shall appoint one of the Non-Executive Directors to be the Vice Chair of the Board of Directors. If the Chair is unable to discharge their office as Chair of the Trust, the Vice Chair of the Board of Directors shall be acting Chair of the Trust.

27.2 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors as Senior Independent Director to act in accordance with NHS England's Code of Governance for NHS Provider Trusts (as may be amended and replaced from time to time), and the Board of Director's Standing Orders. The SID should be available to all stakeholders, particularly Governors and members, should they have concerns which they feel unable to resolve via normal channels, such as through contact with the Chair or Chief Executive, or in circumstances in which such contact would be inappropriate.[4]

Board of Directors - appointment and removal of the Chief Executive Officer and other Executive Directors[5]

28.1 The Non-Executive Directors shall appoint or remove the Chief Executive Officer.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

28.4 The Chief Executive may appoint one of the Executive Directors as Deputy Chief Executive, subject to the approval of the Board's Nominations and Remuneration Committee.

Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986;

29.3 a person who has made a composition or arrangement with, or granted a Trust deed for, their creditors and has not been discharged in respect of it.

29.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Directors are set out at Annex 5.

[3] Code of Governance, provision C.2.13
[4] Code of Governance B.2.11
[5] Code of Governance, provision B.2.12

Board of Directors – meetings

30.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, such as commercial confidentiality.

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.[6]

Board of Directors – standing orders

31.1 The standing orders for the practice and procedure of the Board of Directors are included at Annex 7. Amendment of these Standing Orders does not require amendment of the Constitution, as the current version of Standing Orders is deemed to prevail. Such amendment to be in accordance with paragraphs 4.42 and 12.3 of Annex 7.

Board of Directors - conflicts of interest of Directors

32.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

- 32.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.
- 32.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in paragraph 32.1.1 is not infringed if:

- 32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or
- 32.2.2 The matter has been authorised in accordance with the Constitution.

32.3 The duty referred to in paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In paragraph 32.1.2, “third party” means a person other than:

- 32.4.1 The Trust; or
- 32.4.2 A person acting on its behalf.

32.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware of or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest:

- 32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
- 32.9.2 If, or to the extent that, the Directors are already aware of it;
- 32.9.3 If, or to the extent that, it concerns terms of the Director’s appointment that have been or are to be considered:
  - 32.9.3.1 By a meeting of the Board of Directors, or
  - 32.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

[6] Code of Governance, provision Appendix B 3.3

32.10 For the purposes of paragraph 32.2.2:

32.10.1 A matter shall have been authorised in accordance with the Constitution if it has been approved by the Board of Directors (excluding any Director whose interest is the subject of authorisation) on the basis that to do so would be in the best interests of the Trust.

32.10.2 The Board of Directors may grant any such authorisation in paragraph 32.10.1 subject to such terms and conditions as the Board of Directors thinks fit.

32.10.3 The Board of Directors may decide to revoke or vary any authorisation granted pursuant to paragraph 32.10.1 at any time, but such a decision will not affect anything done by the Director(s) whose interest is the subject of authorisation prior to such revocation or variation.

Board of Directors – remuneration and terms of office

Non-Executive Directors:

33.1 The Nominations and Remuneration Committee of the Council of Governors shall be responsible for the appointment process (and setting the terms and conditions) of the Chair and Non-Executive Directors. A full Council of Governors meeting shall consider and approve the Committee's recommended candidate for appointment at its next meeting.

33.2 The tenure for Non-Executive Directors shall be set at three years. Any re-appointed Non- Executive Director must have had a formal performance evaluation and continue to demonstrate commitment to the role. Any exceptional term beyond six years (e.g., two three-year terms) should be reviewed robustly and subject to an annual re-appointment process. A Non-Executive Director of the Trust (including the Chair) may not hold office for longer than a maximum of nine years in aggregate in the capacity of either the Chair or a Non-Executive Director of the Trust.[7]

33.3 The Nominations and Remuneration Committee of the Council of Governors shall consist of a majority of Governors.[8]

Executive Directors:

33.4 The Nominations and Remuneration Committee of the Board of Directors shall be responsible for the appointment of the Chief Executive and other Executive Directors including deciding their remuneration and allowances, and the other terms and conditions of office.[9]

Registers

The Trust shall have (in paper or electronic format):

34.1 a register of members showing, in respect of each member, the constituency to which they belong;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of Governors;

34.4 a register of Directors; and

34.5 a register of interests of the Directors.

Admission to and removal from the registers

35.1 The Secretary shall remove from the register of members the name of any member who they are made aware is no longer entitled to be a member under the provisions of this Constitution.

[7] Code of Governance, provision B.4.3
[8] Code of Governance, provision B.2.6
[9] Code of Governance, provision B.2.10

Registers – inspection and copies

36.1 The Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

Documents available for public inspection

37.1 The following documents will be available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current Constitution;

37.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

37.1.3 a copy of the latest annual report;

The Trust should make the above documents available upon request.

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

37.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

37.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

37.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

37.2.8 a copy of any final report published under section 65I (administrator's final report),

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

37.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

Auditor

38.1 The Trust shall have an auditor.

38.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

38.3 A person may only be appointed Auditor if they (or in the case of a firm each of its members), is a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 of the 2006 Act.

38.4 The Auditor shall carry out its duties in accordance with Schedule 10 of the 2006 Act and in accordance with any directions given by NHS England on standards, procedures and techniques to be adopted.

~~38.5 The Board of Directors may resolve that its external auditors be appointed to carry out additional services outside the remit of the prescribed Foundation Trust audit work. Any such additional work is to be approved by the Council of Governors in accordance with the Trust's External Auditor Additional Services Policy.~~

Audit Committee

39.1 The Trust shall establish a committee of Non-Executive Directors (at least one of whom should have competence in accounting and/or auditing and recent and relevant financial experience[10]) as an audit committee. The audit committee will perform such monitoring, reviewing and other functions as are appropriate.

39.2 The Trust Chair should not be a member of the Committee and the Vice Chair and Senior Independent Director should not chair the Committee.[11]

Accounts

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

40.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

40.3 The accounts are to be audited by the Trust's auditor.

40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.6 The Accounting Officer shall cause the Trust to:

40.6.1 Send copies of the annual accounts, and any report of the financial auditor on them, to NHS England; and

40.6.2 Once it has done so, lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament.

Annual report, forward plans and non-NHS work

41.1 The Trust shall prepare an Annual Report and send it to NHS England.

41.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Board of Directors.

41.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

41.5 Each forward plan must include information about:

41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry out; and

41.5.2 the income it expects to receive from doing so.

[10] Code of Governance provision D.2.1

[11] Code of Governance provision D.2.1

41.6 Where a forward plan contains a proposal that the Trust carry out an activity of a kind mentioned in paragraph 41.5.1 the Council of Governors must:
- 41.6.1 determine whether it is satisfied that the carrying out of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and
- 41.6.2 notify the Directors of the Trust of its determination.

41.7 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

Presentation of the annual accounts and reports to the Governors and members

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
- 42.1.1 the annual accounts;
- 42.1.2 any report of the auditor on them; and
- 42.1.3 the annual report.

42.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 42.1 with the Annual Members' Meeting.

Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors.

43.3 The Trust headquarters are at Williams Avenue, Dorchester, Dorset, DT1 2JY.

Amendment of the Constitution[12]

44.1 The Trust may make amendments of its Constitution only if:
- 44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and
- 44.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):
- 44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and
- 44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.4 Amendments by the Trust of its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

[12] Code of Governance, provision Appendix B 3.5

Mergers etc. and significant transactions

45.1 The Trust may only apply for a statutory merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

45.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

45.3 For the purposes of paragraph 45.2:

45.3.1 A significant transaction is an investment or divestment; and

45.3.2 A transaction is significant if its value equates to more than 25% of the Trust's:

45.3.2.1 gross assets;

45.3.2.2 income; or

45.3.2.3 gross capital (following completion of the transaction),

calculated with reference to the Trust's opening balance sheet for the financial year in which approval is being sought.

45.3.3 A statutory transaction under paragraph 45.1 is not a significant transaction for the purposes of paragraph 45.2.

45.4 For the avoidance of doubt, for the purposes of paragraph 45.3.1, the term 'transaction' shall not include a contract with a commissioning organisation for the provision of services for the purposes of the health service in England or Wales.

45.5 If more than half of the members of the Council of Governors voting decline to approve a significant transaction or any part of it, the Council of Governors must approve a written Statement of Reasons for its rejection, to be provided to the Board of Directors.

45.6 Nothing in this paragraph shall prevent the Board of Directors from appropriate engagement with the Council of Governors, as it sees fit, to provide information on any other transaction or arrangement which the Trust may enter, which does not constitute a "significant transaction" as defined within paragraph 45.3.

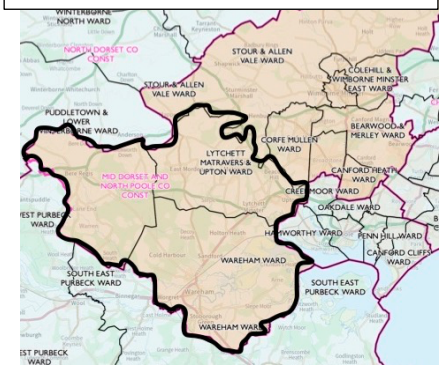
Annex 1 – The Public Constituencies

(Paragraphs 7.1 and 7.3)

The Public Constituency consists of 3 (was 5) constituencies which will be drawn from the parliamentary boundaries established in 2023 (former Local Authorities areas) with some minor amendments to electoral wards and will include a combined South Somerset and Rest of England constituency.

Electoral Wards for the West and South Dorset constituency

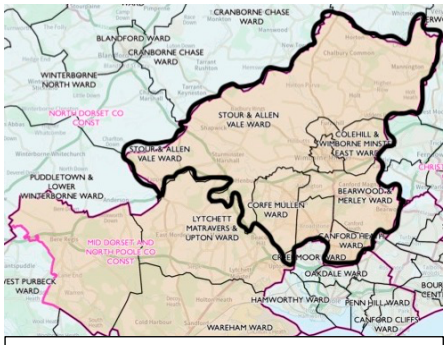
Split of Mid Dorset and North Poole electoral wards



An individual who lives in one of the electoral areas as specified below as an area for a public constituency who may become or continue as a member of the Trust:

Current FT Public Constituency	Old council boundaries (pre 2019)	New parliamentary constituencies, electorate nos. in 2023, and unitary authority		Proposed Public Constituencies and no's of seats
West Dorset (6 seats)	West Dorset District Council	West Dorset	Electorate = 75,390 – Dorset CC	**West & South Dorset (11 seats)** with change of boundary
		Beaminster; Bridport; Chalk Valleys; Charminster St. Mary's; Chesil Bank; Dorchester East; Dorchester Poundbury; Dorchester West;	Eggardon; Lyme & Charmouth; Marshwood Vale; Sherborne East; Sherborne Rural; Sherborne West; Winterborne & Broadmayne; Yetminster	
Weymouth and Portland (5 seats)	Weymouth and Portland Borough Council	South Dorset incl. change of boundary.	Electorate = 76,640 – Dorset CC	
		Chickerell, Littlemoor & Preston, Melcombe Regis, Portland, Radipole,	Rodwell & Wyke, Westham Upwey & Broadwey,	
East Dorset (2 seats) – **Purbeck,** East Dorset & BCP	Purbeck District Council only	Crossways, South East Purbeck, Swanage	polling districts WPU1 and WPU4 - WPU13 in West Purbeck	
	East Dorset District Council (partial)	Mid Dorset & North Poole (partial).	Electorate = 74,305 – Dorset CC	
		Lytchett Matravers & Upton	Wareham West Purbeck	

Electoral Wards for the North and East Dorset constituency



Split of Mid Dorset and North Poole electoral wards

An individual who lives in one of the electoral areas as specified below as an area for a public constituency who may become or continue as a member of the Trust:

Current FT Public Constituency	Old council boundaries (pre 2019)	New parliamentary constituencies, electorate nos. in 2023, and unitary authority		Proposed Public Constituencies and no's of seats
North Dorset (2 seats)	North Dorset District Council	North Dorset incl. change of boundary from West Dorset. Beacon, Blackmore Vale, Blandford, Cranborne & Alderholt, Cranborne Chase, Gillingham, Hill Forts & Upper Tarrants,	Electorate = 72,109 – Dorset CC Puddletown & Lower Winterborne, Shaftesbury Town, Stalbridge & Marnhull, Sturminster Newton, Verwood, Winterborne North	**North & East Dorset (4 seats) with change of boundary**
East Dorset (2 seats) – Purbeck, **East Dorset** & BCP	East Dorset District Council	Mid Dorset & North Poole (partial). Colehill & Wimborne Minster East Corfe Mullen Bearwood & Merley (BCP) Broadstone (BCP)	Electorate = 74,305 – Dorset CC Stour & Allen Vale Wimborne Minster Canford Heath (BCP)	
East Dorset (2 seats) – Purbeck, East Dorset & **BCP**	Christchurch Borough Council	Christchurch incl. change of boundary. Burton & Grange Christchurch Town Commons Ferndown North Ferndown South Highcliffe & Walkford	Electorate = 71,598 – BCP Mudeford, Stanpit & West Highcliffe St Leonards & St Ives West Moors & Three Legged Cross West Parley	
	Poole Borough Council	Poole incl. change of wards moved to Mid Dorset & North Poole. Canford Cliffs Creekmoor Hamworthy Newtown & Heatherlands	Electorate = 72,162 – BCP Oakdale Parkstone Penn Hill Poole Town	

East Dorset (2 seats) – Purbeck, East Dorset & **BCP**	Bournemouth Borough Council	Bournemouth East incl. change of boundary. Electorate = 73,173 BCP Boscombe East & Pokesdown Boscombe West East Cliff & Springbourne East Southbourne & Tuckton Littledown & Iford Moordown Muscliff & Strouden Park Queen's Park West Southbourne	Bournemouth West incl. change of boundary. Electorate = 72,094 BCP Alderney & Bourne Valley Bournemouth Central Kinson Redhill & Northbourne Talbot & Branksome Woods Wallisdown & Winton West Westbourne & West Cliff Winton East	**North & East Dorset (3 seats)** with change of boundary

Electoral Wards for South Somerset and Rest of England

South Somerset and Rest of England (1)	South Somerset District Council and Rest of England	South Somerset and Rest of England	**South Somerset and Rest of England (1)**

The minimum number of members required for a public constituency is 50.

Annex 2 – the Staff Constituency

(Paragraphs 8.4 and 8.5)

The Staff Constituency will not be divided into classes but will consist of four Members to the Council of Governors irrespective of profession or department allowing those members to focus on the development of the Trust rather than on the narrow interests of their respective profession or department.

The minimum number of members in the Staff Constituency is 500.

Annex 3 – Composition of the Council of Governors

(Paragraphs 12.2 and 12.3)

The Council of Governors is to consist of public Governors, staff Governors and appointed Governors from local authorities, universities and partner organisations. The aggregate number of public Governors is to be more than half of the total number of members of the Council of Governors. The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors:

- The interests of the community served by the Trust are appropriately represented;
- The level of representation of the Public Constituencies, the Staff Constituency and the Appointing Organisations achieves an appropriate balance having regard to their legitimate interest in the Trust's affairs;

The Council of Governors of the Trust is to comprise:

Appointed Governors (8)			Tenure	**Role**
Appointed Governors from Statutory Organisations (1)				
~~Integrated Care Board (ICB)~~	~~Dorset ICB~~	~~1~~	~~Organisational tenure = 3 yrs~~	~~To represent the Trust's main commissioners and key health economy partners~~
Local Authority	Dorset Council	1	Organisational tenure = 3 yrs	To represent key local non-NHS local authority health economy partners
Appointed Governors from Partnership Organisations (7)				
Voluntary and Charitable Sector	Age UK Weldmar Hospicecare Trust Friends of Dorset County Hospital Vacancy for further national/regional healthcare charity.	1 1 1 4	Organisational tenure = 3 yrs	To engage and assist the Trust in local developments Additional partnership seat to replace ICB seat
Elected Staff Governors (4)				
	Staff Membership is not split into staff classes	4	3 years	To assist the Trust in development and delivery of services through active representation from those who deliver the services
Elected Public Governors (16)				
Parliamentary Areas	West and South Dorset	11	3 yrs.	To represent the public and patients who are served by the NHS Foundation Trust
	North & East Dorset	4	3 yrs.	
	South Somerset and Rest of England	1	3 yrs.	
Total number of governors (28)				

Annex 4 – Additional Provisions: Council of Governors

(Paragraph 15.3)

Elected Governors

1. A member of the public constituency may not vote at an election for a public Governor unless, not less than seven days before they vote, they have made a declaration in the form specified by the Trust that they are qualified to vote as a member of the public constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

2. The Secretary, in consultation with the respective appointing organisation, is to adopt a process for agreeing the appointment of each of the Appointed Governors.

Lead Governor

3. The Council of Governors shall appoint one of the Governors to be Lead Governor of the Council of Governors, in accordance with the role description within the Code of Governance for NHS Provider Trusts. The Lead Governor may be a Public Governor, an Appointed Governor or a Staff Governor. If more than one nomination is received an anonymous ballot of all the Governors shall be held to fill the position.

4. The Council approve additional duties to the role description within the Code of Governance for NHS Provider Trusts to support the Council in fulfilling its statutory obligations. The term of office of the Lead Governor shall be two years. A Governor may be re-appointed as the Lead Governor by the Council of Governors at the end of that term. Only in exceptional circumstances would a Lead Governor serve for more than two terms.

Further provisions as to eligibility to be a Governor

5. A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

5.1. They are a Director of the Trust or Director of another NHS Foundation Trust;

5.2. They are a member of a committee which has any role on behalf of a local authority or the Welsh Parliament to scrutinise and review health matters including a local authority's scrutiny committee covering health matters;

5.3. They, being a member of the staff constituency, are in receipt of a final written warning under the Trust's disciplinary procedure and the time period for such warning has not expired;

5.4. They have, within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body as outlined in section 9 of the 2006 Act

5.5. They are a person whose tenure of office as the Chair or as a member, Governor or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

5.6. They have had their name removed from any list prepared under chapter 6 of the 2006 Act or the equivalent lists maintained in Wales or has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had their name included in such a list or had their suspension lifted or qualification re-instated (as applicable);

5.7. They are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

5.8. Being a member of one of the public constituencies, they have failed to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors; or

5.9. They have previously been removed as a Governor pursuant to the procedure set out in this Annex or as the Governor of another NHS Foundation Trust, unless the Council of Governors vote by majority approval that they can re-stand for election;

5.10 They are the spouse, partner, parent or child of a member of the Council of Governors or the Board of Directors of the Trust;

5.11 They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

5.12 They are a person who is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council, in accordance with the Medical Act 1983, or has been suspended from that register, and not subsequently had their name returned to the register;

5.13 They are not a fit and proper person for the purposes of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or Condition G4 of the Trust's Licence;

5.14 They are the subject of an order under the Sexual Offences Act 2003;

5.15 They are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list.

Termination of office and removal of Governors

6. A person holding office as a Governor (either elected or appointed) shall immediately cease to do so if:

6.1. They resign by notice to the Secretary;

6.2. They fail to attend three meetings of the Council of Governors either consecutively or in any period of 12 months unless the other Governors are satisfied that:

6.2.1. The absences were due to reasonable causes; and

6.2.2. They will be able to start attending meetings of the Trust again within such a period as the Council of Governors considers reasonable;

6.3. They are disqualified from continuing to be a Governor under paragraph 5 above;

6.4. They have failed without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

6.5. If within one calendar month of appointment, they have failed to sign and deliver a statement to the Secretary in a form required by the Trust confirming acceptance and agreement to abide by the Trust's Code of Conduct for Governors;

7. A Governor may also be removed from the Council of Governors on the grounds that:

7.1. They committed a serious breach of the Trust's Code of Conduct for Governors; or

7.2. They have acted in a manner detrimental to the interests of the Trust; or

7.3. They have brought the Trust into disrepute.

and the Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor;

8. Where a person has been elected or appointed to be a Governor and they become disqualified for appointment under the provisions of paragraph 5 above, they shall notify the Secretary in writing of such disqualification as soon as practicable. If it comes to the notice of the Secretary at the time of their appointment or election or later, that the Governor is so disqualified, the Secretary shall immediately declare that the person in question is disqualified and notify them in writing to that effect. Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and they shall cease to act as a Governor;

9. Where a person has been declared disqualified by the Secretary under the provisions of paragraph 8, they may appeal the Secretary's decision to the Chair, whose decision on the matter will be final. The appeal must be submitted in writing within a 6-month period from the disqualification;

10. The Council of Governors is required to agree a clear policy and a fair process for consideration of the removal of any Governor (elected or appointed) under paragraphs 6.2, 6.4, 6.5 and/or paragraph 7 above. The policy is set out in the "Standard Operating Procedure (SOP) for the Removal of a Governor from the Council of Governors" and it looks firstly to find a local resolution to any allegations or concerns that have been raised against the Governor. Where local resolution is not possible, an investigation will be carried out and its findings considered by the Council's Standards Committee.

11. The Council of Governors will establish a Standards Committee, to be chaired by the Lead Governor. The Committee will consider the investigation carried out into the allegations or concerns raised that may lead to the removal or censure of a Governor. The Standards Committee shall provide a mechanism for Governor peer review and accountability and shall be established with formal Terms of Reference, to be agreed by the Council of Governors. The Terms of Reference must make provision for an alternative committee chair if the investigation involves the Lead Governor and one of its members must be a Lead Governor from a different Council of Governors. The decision of the Standards Committee will be communicated to the Governor under investigation and the action recommended by the Committee should be implemented by the Chair.

12. Where the action recommended by the Standards Committee is the removal of the Governor from the Council of Governors, a resolution to that effect must be approved by a majority of the Governors present and voting at a Council of Governors meeting;

13. A Governor who resigns or whose term of office ends under paragraph 6 shall not be eligible to stand for re-election, or for re-appointment in the case of Appointed Governors, for a period of 12 months from the end of their term of office. For the avoidance of doubt, a Governor who is removed from office under paragraph 12 shall not be eligible to stand for re-election, or for re-appointment in the case of Appointed Governors, for a period of 3 years and they will require approval from the majority of the Council of Governors present and voting at a Council of Governors meeting before they can re-stand for election or re-appointment;[13]

Vacancies amongst Governors

14. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply;

15. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office;

16. Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

16.1. To call an election within three months to fill the seat for the remainder of that term of office; or

16.2. To invite the next highest polling candidate for that seat at the most recent election to fill the seat until the next election or for the unexpired term of office of the vacant seat, whichever is the earlier, subject to a minimum term of six months, at which time the seat will fall vacant and subject to election. Should that candidate decline, the Council of Governors may approach each of the remaining next highest polling candidates in order until the seat is filled, save that the Council of Governors may adopt this process on no more than two occasions within 12 months of the last election for that seat; or

16.3. If the unexpired period of the term of office is less than twelve months, to leave the seat vacant until the next elections are held.

17. For the purposes of determining the length of time a Governor has held office (and therefore their eligibility to seek re-election or re-appointment as a Governor according to paragraph 14 of the Constitution), the period between a Governor taking office as a consequence of paragraphs 13 to 15 of Annex 4 and the end of that term of office shall be treated as one year.

Declaration

18. Section 60 of the 2006 Act requires persons standing for and voting in the elections to make a declaration setting out the particulars of their qualifications to vote or stand as a member of the constituency for which the election is being held. This requirement does not apply to Staff Governors (Section 60(4) of the 2006 Act). A member of the Public Constituency may not stand for, or vote at, an election for a Public Governor unless within seven days before they vote they have made a declaration in the forms specified below that they are qualified to vote as a member of the relevant area of the Public Constituency and (if standing for election) that they are not prevented from being a member of the Council of Governors. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

[13] Annex 4, paragraph 5.9

19. The declarations referred to in paragraph 16 will be as follows:

Declaration pursuant to S60(1) of entitlement to vote in an election for the Public Constituency:
"I hereby declare that I am at the date of this declaration a member of the Public Constituency, by reason of living at [ ] in the constituency for which this election is being held"

Declaration pursuant to S60(2) of entitlement to stand as a Governor:
"I hereby declare that I am at the date of this declaration a member of the Public Constituency by reason of living at [ ] in the constituency for which this election is being held and I am not prevented from being a member of the Council of Governors by reason of any of the matters set out in Annex 4, Paragraph 5 of the Constitution of the Trust"

Declaration to be made by Governors prior to Council of Governors' meetings pursuant to S60(3):
Declaration to the Secretary of Dorset County Hospital NHS Foundation Trust
"I hereby declare that at the date of this declaration I am not prevented from being a member of the Council of Governors under the provisions in the Constitution."

Annex 5 – Additional Provisions: Board of Directors

No equivalent Annex in DCH original but contents spread across the other Annexes. This amalgamates those matters and aligns the structure for DHC and DCH.

Appointment of Chair and other Non-Executive Directors

The Chair and the Non-Executive Directors are to be appointed by the Council of Governors in accordance with paragraph 26 of the Constitution using the following procedure:

1. The Council of Governors will maintain a policy for the composition of the Non-Executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

2. The Council of Governors will normally work with an external organisation recognised as expert at appointments to identify the skills and experience required for Non-Executive Directors.

3. Appropriate candidates (not usually more than five for each vacancy) will be identified by a Nominations and Remuneration Committee through a process of open competition, which take account of the policy maintained by the Council of Governors and the skills and experience required.

4. The Nominations and Remuneration Committee will comprise the Chair (or, when a Chair is being appointed, the Senior Independent Director unless they are standing for appointment, in which case another Non- Executive Director), two public Governors, one staff Governor and one appointed Governor. The Nominations and Remuneration Committee will be advised by an independent assessor, who may be a chair of another NHS foundation Trust. The Chief Executive will be entitled to attend meetings of the Nominations and Remuneration Committee unless the Committee decides otherwise and the Committee shall take into account the Chief Executive's views.

5. The Nominations and Remuneration Committee will make a recommendation to the Council of Governors for approval.

6. Any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors has approved.

Removal of Chair and other Non-Executive Directors

The Chair or another Non-Executive Director may be removed by the Council of Governors in accordance with paragraph 26 of the Constitution, subject to the following procedure:

7. Any proposal for removal must be proposed by a Governor and seconded by not less than eight Governors including at least two elected Governors and two appointed Governors.

8. Written reasons for the proposal shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

9. In making any decision to remove a Non-Executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chair.

10. If any proposal to remove a Non-Executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

Further provisions as to eligibility to be a Director

11. A person may not become a Director of the Trust, and if already holding such office, will immediately cease to do so if:

11.1. They are a Governor of the Trust or a Governor of another NHS foundation trust;

11.2. They are a member of the Trust's Patients Forum;

11.3. They are a Director, or holds an equivalent role, of another NHS Trust or NHS Foundation Trust except with the approval of the Board of Directors and in the case of a Non-Executive Director, with the approval of the Council of Governors;

11.4. They have, or is a member of a committee which has, any role on behalf of a local authority or the Welsh Parliament to scrutinise and review health matters including a local authority's scrutiny committee covering health matters;

11.5. They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

11.6. They have, within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body as outlined in section 9 of the 2006 Act ;

11.7. They are a person whose tenure of office as the Chair or as a member, Governor or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

11.8. They have had their name removed from any list prepared under chapter 6 of the 2006 Act or the equivalent lists maintained in Wales or has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had their name included in such a list or had their suspension lifted or qualification re-instated (as applicable);

11.9. They are a person who is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council, in accordance with the Medical Act 1983, or has been suspended from that register, and not subsequently has their name returned to the register.

11.10. They fail to disclose an interest required to be disclosed under the Constitution and three quarters of the Board (and, in the case of a Non-Executive Director, a majority of the Council of Governors) agreed that they should permanently vacate office;

11.11. In the case of a Non-Executive Director, they have failed without reasonable cause to fulfil any training requirement established by the Board of Directors;

11.12. They have failed to sign and deliver to the Secretary a statement in the form requirement by the Board of Directors confirming acceptance of the code of conduct for Directors;

11.13. They are not a fit and proper person for the purposes of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or Condition G4 of the Trust's Licence;

11.14. Disclosures revealed by a Disclosure and Barring Service check against them are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

11.15. They are the subject of an order under the Sexual Offences Act 2003.

11.16. They are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list

Remuneration, allowances and expenses

12. The Trust may reimburse Directors for travelling and other costs and expenses at such rates as the Nominations and Remuneration Committee decides. These rates are to be disclosed in the annual report.

13. The remuneration and allowances for Directors are to be disclosed in the annual report.

Secretary

14. The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, the Chief Executive or the Chief Finance Officer.

15. The Secretary's functions shall include:

15.1. acting as Secretary to the Council of Governors, the Board of Directors and any committees of the Board;

15.2. summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors and keeping the minutes of those meetings;

15.3. keeping the register of members and other registers and books required by this Constitution to be kept;

15.4. having charge of the Trust's seal;

15.5. publishing to members in an appropriate form information which they should have about the Trust's affairs;

15.6. preparing and sending to NHSI and any other statutory body all returns which are required to be made.

16. The Secretary is to be appointed and removed by the Board of Directors.

Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors

(Paragraph 18)

Interpretation

1.1 Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they shall be advised by the Secretary).

1.2 If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

1.3 Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

Board of Directors shall mean the Chair and Non-Executive Directors and the Executive Directors.

Chair is the person appointed as Chair by the Council of Governors in accordance with this Constitution. The expression "the Chair" shall be deemed to include the Vice Chair or otherwise a Non-Executive Director appointed to preside for the time being over meetings.

Chief Executive shall mean the Chief Executive officer of the Trust.

Committee shall mean a committee appointed by the Council of Governors. Such committees shall be advisory only.

Committee members shall be persons formally appointed by the Council of Governors to sit on or to chair specific committees.

Constitution means the Constitution of the Trust and all annexes to it, as may be amended from time to time.

Council of Governors means the Council of Governors of the Trust

Director shall mean a person appointed to the Board of Directors in accordance with the Trust's Constitution and includes the Chair.

Executive Director means a Director appointed by the relevant Committee of the Board who is a full or part-time employee of the Trust or the holder of an executive office

Governor means a Governor on the Council of Governors.

Lead Governor means the person(s) appointed by the Council of Governors in accordance with Annex 4 paragraphs 3 and 4 of the Constitution to be Lead Governor of the Council of Governors.

Meeting means a duly convened meeting of the Council of Governors;

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

Nominated Officer means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

Non-Executive Director means a Director appointed by the Council of Governors who is not a full or part-time employee of the Trust or the holder of an executive office

Officer means an employee of the Trust.

Question on Notice means a question from a Governor (notice of which has been given pursuant to Standing Order 4.7.2) about a matter over which the Council has powers or duties or which affects the services provided by the Trust;

Secretary means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary, including a joint assistant or deputy secretary.

Senior Independent Director means one of the Non-Executive Directors who is appointed to be available to Governors if they have concerns that contact through the usual channels has failed to resolve. The Senior Independent Director could be the Vice Chair

SOs means Standing Orders.

General Information

2.1. These Standing Orders for the practice and procedure of the Council of Governors are the standing orders referred to in paragraph 18 of the Constitution. They may be amended in accordance with the procedure set out in Standing Order 4.14 below.

2.2. The purpose of the Council of Governors' Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all meetings of the Council of Governors and associated deliberations. The Council shall always seek to comply with the Trust's Code of Conduct for Governors.

2.3. All business shall be conducted in the name of the Trust.

2.4. A Governor who has acted honestly and in good faith will not have to meet out of their own personal resources any personal civil liability which is incurred in the execution or purported execution of their functions as a Governor save where the Governor has acted recklessly. Any costs arising in this way will be met by the Trust. On behalf of the Council of Governors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

Composition of the Council of Governors

3.1. The composition of the Council of Governors shall be in accordance with paragraph 12 and Annex 3 of the Constitution.

3.2. If the person presiding at any meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, a Non-Executive Director will chair that part of the meeting.

3.3. A Senior Independent Director will be appointed to act as a further point of contact with the Council of Governors in accordance with paragraph 27 of the Constitution.

Meetings of the Council of Governors

4.1. Admission to meetings

4.1.1 Meetings of the Council of Governors must be open to the public (which, for the avoidance of doubt, includes representatives of the press), subject to 4.1.2 and 4.1.3 below.

4.1.2 The Council of Governors may resolve to exclude members of the public or a representative from the press from any meeting or part of a meeting for reasons of commercial confidentiality or for other special reasons.

4.1.3 The Chair may exclude any member of the public or representative from the press from the meeting of the Council of Governors if they consider that that member of the public or representative from the press is interfering with or preventing the proper conduct of the meeting or for other special reasons.

4.1.4 Meetings of the Council of Governors shall be held at least four times each financial year at such times and places that the Chair may determine.

4.1.5 In exceptional circumstances, a member of the Council who is not present at the meeting may participate in the meeting and count towards the quorum if the absent member can hear the voices of the other members and they can hear the voice and see the absent member director by video or computer link.

4.1.6 Without prejudice to the power of the Council of Governors to require one or more of the Directors to attend a meeting of the Council of Governors for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and decide whether to propose a vote on the Trust's or Directors' performance) at paragraph 17.3 of the Constitution, the Council of Governors may invite the Chief Executive, one or more Directors or a representative of the auditor or other advisors, as appropriate, to attend any meeting of the Council of Governors to enable Governors to raise questions about the Trust's affairs.

4.2. Calling Meetings

4.2.1 Meetings of the Council of Governors may be called by the Secretary or the Chair or ten Governors (including at least five elected Governors and one appointed Governor) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If upon receipt of such a request, the Secretary fails to call such a meeting, the Chair or four Governors, whichever is the case, shall call the meeting.

4.2.2 All decisions taken in good faith at a meeting of the Council of Governors shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting or the appointment or election of the Governors attending the meeting.

4.3. Notice of Meetings

4.3.1 The Secretary shall deliver a schedule of the dates, times and venues of meetings of the Council of Governors for each financial year, three months in advance of the first meeting of the Council of Governors to be called, duly signed by the Chair or by an Officer of the Trust authorised by the Chair to sign on their behalf, to every Governor, or send such schedule by post to the usual place of residence of such Governor. The Council will meet no less than four times in a financial year. Lack of service of the notice on any Governor shall not affect the validity of a meeting, subject to 4.3.4 below.

4.3.2 Notwithstanding 4.3.1, and subject to 4.3.3, should an additional meeting of the Council of Governors be called pursuant to 4.2, the Secretary shall, as soon as possible, deliver written notice of the date, time and venue of the meeting to every Governor, or send by post to the usual place of residence of such Governor, so as to be available to them at least fourteen days but not more than twenty-eight days' notice before the meeting. Such notice will also be published on the Trust's website.

4.3.3 The Chair may waive the notice required pursuant to 4.3.2 in the case of emergencies or in the case of the need to conduct urgent business.

4.3.4 Subject to 4.3.3, failure to serve notice on more than three quarters of Council of Governors will invalidate any meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.3.5 Before each meeting of the Council of Governors, the Secretary shall ensure that every Governor is provided with reasonable notice of the details of the business to be transacted in it. In the case of a meeting called by Governors in default of the Chair, no business shall be transacted at the meeting other than that specified in the notice.

4.4. Setting the Agenda

4.4.1 The Secretary shall ensure an agenda, minutes of the previous meeting of the Council of Governors, copies of any questions on notice and/or motions on notice to be considered at the relevant meeting of the Council of Governors. Supporting papers are circulated to every Governor via electronic means, or made available in paper copy, as required, normally at least five days in advance of the meeting.

4.4.2 Approval of the minutes of the previous meeting of the Council of Governors will be a specific item on each agenda.

4.4.3 In the case of a meeting called by the Chair, a Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten working days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.5. Chair of Meeting

4.5.1. At any meeting of the Council of Governors, the person presiding shall be determined in accordance with paragraph 17.1 of the Constitution.

4.5.2. At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting or the Council of Governors is meeting to appoint or remove the Chair or decide their remuneration and allowances and other terms and conditions of office or outcome of annual appraisal, the Vice Chair shall preside.

4.5.3. If the Vice Chair is absent from the meeting, or the Council of Governors is meeting to appoint or remove the Vice Chair or decide their remuneration and allowances and other terms and conditions of office, the Senior Independent Director shall preside.

4.5.4. If the person presiding at any meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, a Non-Executive Director will chair that part of the meeting.

4.6. Notices of Motions

4.6.1 Motions by the Council of Governors may only concern matters for which the Council of Governors has a responsibility or which affect the services provided by the Trust.

4.6.2 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governor who gave it and the signature of four other Governors. When any such motion has been disposed of by the Council of Governors it shall not be competent for any Governor to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

4.6.3 Subject to 4.6.5 and except in the circumstances covered by 4.8, Governors desiring to move or amend a motion shall send a written notice thereof at least ten working days before the meeting at which it is proposed to be considered to the Secretary, such written notice to be signed or transmitted by at least two Governors. For the purposes of this 4.6, receipt of such motions by electronic means is acceptable.

4.6.4 Upon receipt of a motion, the Secretary shall:

4.6.4.1 acknowledge receipt in writing to each of the Governors who signed or transmitted it; and

4.6.4.2 insert this in the agenda for that meeting, together with any relevant papers.

4.6.5 The following motions may be moved at any meeting without notice:
- 4.6.5.1 To amend the minutes of the previous meeting of the Council of Governors in order to ensure accuracy;
- 4.6.5.2 To change the order of business in the agenda for the meeting;
- 4.6.5.3 To refer a matter discussed at a meeting to an appropriate body or individual;
- 4.6.5.4 To appoint a working group arising from an item on the agenda for the meeting;
- 4.6.5.5 To receive reports or adopt recommendations made by the Board of Directors;
- 4.6.5.6 To withdraw a motion;
- 4.6.5.7 To amend a motion;
- 4.6.5.8 To proceed to the next business on the agenda;
- 4.6.5.9 That the question be now put;
- 4.6.5.10 To adjourn a debate;
- 4.6.5.11 To adjourn a meeting;
- 4.6.5.12 To exclude the public and press from the meeting in question pursuant to 4.1.2 (in which case, the motion shall state on what grounds such exclusion is appropriate).
- 4.6.5.13 To not hear further from a Governor, or to exclude them from the meeting in question (if a member persistently disregards the ruling of the Chair or behaves improperly or offensively or deliberately obstructs business, the Chair, in their absolute discretion, may move that the Governor in question will not be heard further at that meeting and, if seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair may move that either the Governor leaves the meeting room or that the meeting is adjourned for a specific period. If seconded, that motion will be voted on without discussion.)
- 4.6.5.14 To give the consent of the Council of Governors to any matter on which its consent is required pursuant to the Constitution.

4.6.6 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.7. Questions on Notice at Meetings

4.7.1 Subject to 4.7.2, a Governor may ask a Question on Notice of:
- 4.7.1.1 the Chair;
- 4.7.1.2 another Governor;
- 4.7.1.3 an Executive Director; or
- 4.7.1.4 the chair of any sub-committee or working group of the Council.

4.7.2 Except in the circumstances covered by 4.8, notice of a Question on Notice must be given in writing to the Secretary at least ten days prior to the relevant meeting. For the purposes of this Standing Order 4.7, receipt of any such Questions on Notice via electronic means is acceptable.

4.7.3 A response to a Question on Notice may take the form of:
- 4.7.3.1 A direct oral answer at the relevant meeting (which may, where the desired information is in a publication of the Trust or other published work, take the form of a reference to that publication);
- 4.7.3.2 Where a direct oral answer cannot be given, a written answer which will be circulated as soon as reasonably practicable to the questioner and circulated to the remaining Governors with the agenda for the next meeting.

4.7.4 Supplementary questions for the purpose of clarification of a reply to a Question on Notice may be asked at the absolute discretion of the Chair.

4.8. Urgent motions or questions

4.8.1 The Chair may, in their opinion, table an urgent motion or question.

4.8.2 A Governor may submit an urgent motion or question in writing to the Secretary before the commencement of the meeting at which it is proposed it should be considered.

4.9. Reports from the Executive Directors

4.9.1 At any meeting, a Governor may ask any question on any report by an Executive Director or another Officer through the Chair without notice, after that report has been received by or while such report is under consideration by the Council of Governors at the meeting.

4.9.2 Unless the Chair decides otherwise, no statements will be made by a Governor other than those which are strictly necessary to define or clarify any questions posed pursuant to 4.9.1 and, in any event, no such statement may last longer than three minutes each.

4.9.3 A Governor who has asked a question pursuant to 4.9.1 may ask a supplementary question if the supplementary question arises directly out of the reply given to the initial question.

4.9.4 The Chair may, in their absolute discretion, reject any question from any Governor if, in the opinion of the Chair, the question is substantially the same and relates to the same topic as a question which has already been put to the meeting or a previous meeting.

4.9.5 At the absolute discretion of the Chair, questions may, at any meeting which is held in public, be asked of the Executive Directors present by members of the Trust or any other members of the public present at the meeting.

4.10. Speaking

This Standing Order applies to all forms of speech/debate by Governors or members of the Trust and public in relation to a motion or question under discussion at a meeting of the Council of Governors.

4.10.1 Any approval to speak must be given by the Chair.

4.10.2 Speeches must be directed to the matter, motion or question under discussion or to a point of order.

4.10.3 Unless in the opinion of the Chair it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech nor any reply may exceed three minutes.

4.10.4 The Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

4.10.5 A person who has already spoken on a matter at a meeting may not speak again at that same meeting in respect of that matter unless exercising a right of reply or speaking on a point of order.

4.11. Chair's Ruling

Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.12. Voting

4.12.1 Subject to the provisions of this Constitution, decisions at meetings shall be determined by a majority of the votes of the Governors present and voting.

4.12.2 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request or if the Chair so directs.

4.12.3 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.12.4 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.12.5 In no circumstances may an absent Governor vote by proxy. Subject to paragraph 4.17.3, absence is defined as being absent at the time of the vote.

4.12.6 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a Governor on the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors and every agenda for meetings of the Council of Governors shall draw this to the attention of the elected Governors.

4.13. Suspension of Standing Orders (SOs)

4.13.1 Except where this would contravene any statutory provision or a direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present and that a majority of those present vote in favour of suspension.

4.13.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.13.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.13.4 No formal business may be transacted while SOs are suspended.

4.13.5 The Trust's Audit Committee shall review every decision to suspend SOs.

4.14. Variation and Amendment of Standing Orders

These Standing Orders shall be amended only in accordance with the procedure set out in paragraph 44 of the Constitution and only if:

4.14.1 a motion to amend the Standing Orders is signed by five Governors (including at least three elected Governors and two appointed Governors) and submitted to the Secretary in writing at least 21 days before the meeting at which the motion is intended to be proposed; and

4.14.2 the majority of the Governors present and voting vote in favour of the amendment.

4.15. Record of Attendance

4.15.1 The names of the Governors present at the meeting (including when present pursuant to paragraph 4.17.3) shall be recorded in the minutes.

4.15.2 Governors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question in order that their apologies are submitted.

4.16. Minutes

4.16.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting.

4.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.16.3 The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public and press are excluded pursuant to 4.1.2 unless otherwise required by law.

4.17. Quorum

4.17.1 Ten Governors shall form a quorum including not less than five elected Governors, and not less than one appointed Governor.

4.17.2 If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.17.3 The Council of Governors may agree that its members can participate in its meetings by live and uninterrupted video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

Arrangements for the Exercise of Functions by Delegation

5.1 The Council of Governors may not delegate any of its powers to a committee or sub-committee, although it may appoint committees consisting of its members, Directors and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties. Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

Confidentiality

6.1 A Governor on the Council of Governors shall not disclose a matter dealt with by, or brought before, the Council of Governors without its permission unless:

6.1.1 it is reported to the Council of Governors; or

6.1.2 the matter is in the public domain; or

6.1.3 disclosure is required by law.

6.2 Members of the Nominations and Remuneration Committee shall not disclose any matter dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the Committee resolves that it is confidential.

Declaration of Interests and Register of Interests

7.1. Governors are required to comply with the Trust's Standards of Business Conduct and to declare interests to the Council in accordance with paragraph 20 of the Constitution and any other material interest as defined below. All Governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.2. Subject to the exceptions in 7.3, a "material interest" is:

7.2.1 any Directorship of a company;

7.2.2 any interest or position in any firm, company, business or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Trust;

7.2.3 any interest in an organisation providing health and social care services to the National Health Service;

7.2.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.2.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks.

7.3. The exceptions which shall not be treated as material interests for the purposes of these provisions are as follows:
- 7.3.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;
- 7.3.2 an employment contract with the Trust held by a Staff Governor;
- 7.3.3 an employment contract with a local authority held by a Local Authority Governor;
- 7.3.4 an employment contract with or other position of authority within an appointing organisation held by an Appointed Governor.

7.4. Any Governor who has an interest in a matter to be considered by the Council of Governors (whether because the matter involves a firm, company, business or organisation in which the Governor or their spouse or partner has a material interest or otherwise) shall declare such interest to the Council of Governors and:
- 7.4.1 shall withdraw from the meeting;
- 7.4.2 play no part in the relevant discussion or decision; and
- 7.4.3 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

7.5. Any Governor who fails to disclose any interest or material interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

7.6. If a Governor has any doubt about the relevance of an interest, they should discuss it with the Chair who shall advise them whether or not to disclose the interest.

7.7. At the time a Governor's interests are declared, they should be recorded in the Council of Governors' minutes and entered on a Register of Interests of Governors to be maintained by the Secretary. Any changes in interests should be declared at the next meeting of the Council of Governors following the change occurring.

7.8. Governors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report.

Register of Interests

8.1. The Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

8.2. Details of the Register will be kept up to date and reviewed annually.

8.3. The Register will be available to the public.

Compliance - Other Matters

9.1 All Governors shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the Trust.

9.2 All Governors of the Trust shall comply with Standing Financial Instructions prepared by the Chief Finance Officer and approved by the Board of Directors for the guidance of all staff employed by the Trust.

9.3 All Governors must behave in accordance with the Trust's Code of Conduct for Governors as amended from time to time and the seven Nolan principles of behaviour in Public Life: -
- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty, and
- Leadership.

Resolution of Disputes with Board of Directors

10.1 Should a dispute arise between the Council of Governors and the Board of Directors, then the disputes resolution procedure set out below shall be followed.

10.2 The Chair, or Vice Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

10.3 Failing resolution under 10.2 above, then the Board of Directors or the Council of Governors, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4 The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board of Directors or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5 The Chair or Vice Chair (if the dispute involves the Chair) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.2 above shall be repeated. The Disputes Statement must this time set out whether the referral of matter to independent mediation has been considered and if the option of independent mediation has been rejected or has proven unsuccessful in facilitating a resolution.

10.6 If, in the opinion of the Chair or Vice Chair (if the dispute involves the Chair) and following the further discussions/independent mediation prescribed in 10.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Vice Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and Board of Directors accordingly.

10.7 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8 On the unsatisfactory completion of this disputes process, the view of the Board of Directors shall prevail.

10.9 Nothing in this procedure shall prevent the Council of Governors, if it so desires and acting through the Lead Governor, from informing NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors that the Trust is not acting in accordance with the terms of its Constitution or not complying with the terms of the 2006 Act.

Council Performance

11.1 The Chair shall, at least annually, lead a performance assessment process for the Council of Governors to enable the Council of Governors to review its roles, structure and composition, and procedures, taking into account emerging best practice.

11.2 The performance assessment process shall include a review of the input into the Council of Governors of each appointing organisation.

Annex 7 – Standing Orders for the Practice and Procedure of the Board of Directors

(Paragraph 31)

Introduction

1.1 The Dorset County Hospital NHS Foundation Trust is a public benefit corporation. The Trust is established under the National Health Service Act 2006 (the 2006 Act).

1.2 These Board Standing Orders form a core part of the governance framework within which the Board, Committees, Directors and staff must operate. They should be considered in conjunction with the Matters Reserved for the Board, the Scheme of Delegation and the Standing Financial Instructions.

1.3 All Executive and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

Interpretation

2.1. Save as permitted by law, and subject to the Constitution, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (SOs) (on which they should be advised by the Secretary).

2.2. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

2.3. Any expression to which a meaning is given in the 2006 Act and other Acts relating to the National Health Service shall have the same meaning in this interpretation and in addition:-

Accounting Officer shall be the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive
Appointed Governor means an appointed representative from a key stakeholder
Board or Board of Directors shall mean the Chair, Non-Executive Directors and the Executive Directors appointed in accordance with the Constitution
Budget shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust
Chair is the person appointed by the Council of Governors in accordance with the Constitution to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole
Chief Executive shall mean the Chief Executive Officer of the Trust
Chief Finance Officer shall mean the chief finance officer of the Trust
Committee shall mean a committee appointed by the Board
Committee members shall be persons formally appointed by the Board to sit on or to chair specific committees
Constitution shall mean the Constitution with any variations from time to time approved by the Board of Directors and the Council of Governors
Council of Governors means the Council of Governors of the Trust as constituted in accordance with the Constitution
Director shall mean a person appointed as a Director of the Board in accordance with the Constitution and includes the Chair
Executive Director means a Director appointed by the relevant Committee of the Board who is a full or part-time employee of the Trust or the holder of an executive office
Motion means a formal proposition to be discussed and voted on during the course of a meeting
Nominated officer means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs

Non-Executive Director shall mean a member of the Board of Directors who is not an employee of the Trust and who is appointed by the Council of Governors in accordance with the Constitution
Officer means an employee of the Trust
Petition means a formal written request sent into the Trust by members of the public calling for some form of action by the Board.
Secretary means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary of the Trust, including a Joint, Assistant or Deputy Secretary
Senior Independent Director means one of the Non-Executive Directors who is appointed to be available to Governors if they have concerns that contact through the usual channels has failed to resolve. The Senior Independent Director could be the Vice Chair
SFIs means Standing Financial Instructions
SOs means Standing Orders
Trust means Dorset County Hospital NHS Foundation Trust which is a public benefit corporation
Vice Chair means the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent for any reason or is unable to act due to a conflict of interest

The Trust

3.1 All business shall be conducted in the name of the Trust.

3.2 All funds received in Trust shall be in the name of the Trust as corporate trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3 Directors acting on behalf of the Board as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission for England and Wales and to NHSE. Accountability for non-charitable funds held on trust is only to NHSE.

3.4 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Matters Reserved for the Board and the Scheme of Delegation for the Board and have effect as if incorporated into the SOs.

3.5 **Composition of the Trust Board of Directors** - The composition of the Board of Directors shall be as set out in paragraph 23 of the Trust's Constitution.

3.6 **Appointment of the Chair and Directors -** The Chair and Non-Executive Directors are appointed in accordance with paragraph 26 of the Constitution and Executive Directors in accordance with paragraph 28 of the Constitution.

3.7 The roles of the Chair and the Chief Executive must not be undertaken by the same individual.

3.8 The Chief Executive should not go on be the Chair of the same NHS Foundation Trust

3.9 **Terms of Office of the Chair and Directors -** The procedure governing the period of tenure of office of the Chair and Directors is contained in paragraph 33 of the Constitution.

3.10 **Appointment of Vice Chair -** For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Council of Governors may appoint a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify on appointing them.

3.11 Any Non-Executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Chair and/or the Secretary and the Council of Governors may thereupon appoint another Non- Executive Director as Vice Chair in accordance with paragraph 3.6.

3.12 **Powers of Vice Chair -** Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, the Vice Chair shall act as Chair until a new Chair is appointed in accordance with paragraph 26 of the Constitution or the existing Chair resumes their duties, as the case may be. References to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice Chair.

3.13 **Shared roles for Board Directors** - Where more than one person is appointed to share a post on the Board which qualifies the holders for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count for the purpose of Standing Order 3.6 as one person.
Where a post of a Board member is shared by more than one person:
(a) both shall be entitled to attend meetings of the Board
(b) either shall be eligible to vote in the case of agreement between them
(c) in the case of disagreement between them no vote should be cast
(d) the presence of either or both shall count as one person for the quorum.

3.14 **Board appointments made jointly with other NHS bodies** – For the avoidance of doubt, any board appointment to support joint working arrangements as set out in paragraph 4.6 – 4.8 of the Constitution must, where appropriate, be made in accordance with paragraph 11.3 of Annex 5.

Meetings of the Board of Directors

4.1 Meetings of the Board of Directors must be open to the public, unless the Board in its absolute discretion decides otherwise in relation to all or part of such meetings for reasons of commercial sensitivity or for other special reasons.

4.2 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption. The Chair may exclude any member of the public or representative from the press from the meeting of the Board of Directors if they consider that that member of the public or representative from the press is interfering with or preventing the proper conduct of the meeting.

4.3 Any record of the proceedings taken by the public or representatives of the press shall only be in writing unless otherwise agreed by the Board of Directors.

4.4 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board may determine.

The Chair of the Trust or Secretary may call a meeting of the Board of Directors at any time. At least one-third of the whole number of Board members may call a meeting of the Board at any time upon submitting a request in writing to the Secretary. If a meeting is not then called within a period of at least fourteen but not more than twenty-eight days of a request being presented, then one-third or more Directors may call such a meeting.

All decisions taken in good faith at a meeting of the Board of Directors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, a vacancy on the Board of Directors, or defect in the appointment of the Directors attending the meeting.

4.5 **Notice of Meetings** - Before each meeting of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every Director, or sent by post or email to their usual place of residence, so as to be available to them at least five working days before the meeting. The Chair may waive the notice required pursuant to this paragraph in the case of emergencies or in the case of the need to conduct urgent business.

4.6 Lack of service of the notice on any Director shall not affect the validity of a meeting.

4.7 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.8 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.9 A public notice of the date, time and place of each Board meeting will also be displayed at the Trust's headquarters at least three working days before the meeting.

4.10 **Setting the Agenda** - The agenda for all the meetings of the Trust will be prepared by the Chair and Chief Executive, assisted by the Secretary.

4.11 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

4.12 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten working days before the meeting, subject to SO 4.5. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.13 **Petitions -** Where a petition has been received by the Trust, the Chair shall decide whether this should be placed before the Board of Directors and/or the Council of Governors.

4.14 **Chair of Meeting** - At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and they are present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive Director as the Directors present shall choose shall preside.

4.15 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

4.16 **Quorum** - No business shall be transacted at a meeting of the Board of Directors unless at least one third of the whole number of Directors is present, including at least one Executive Director and one Non-Executive Director.

4.17 An officer in attendance for an Executive Director at the Board of Directors but without formal acting up status may not count towards the quorum.

4.18 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7 and/or 8), they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.19 **Annual Members' Meeting** - In accordance with the Constitution the Trust will publicise and hold a members' meeting (the "Annual Members' Meeting") within nine months of the end of the financial year.

4.20 **Notices of Motion** - A Director desiring to move or amend a motion shall send a written notice thereof at least ten working days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 4.7.

4.21 **Withdrawal of Motion or Amendments** - The proposer may withdraw a motion or amendment, once moved and seconded, with the concurrence of the seconder and the consent of the Chair.

4.22 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be possible for any Director other than the Chair to propose a motion to the same effect within six months; however, the Chair may do so if they consider it appropriate.

4.23 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any consequent amendment to it.

4.24 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.25 Subject to the agreement of the Chair, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.26 **Attendance at Meetings**

4.26.1. The Board of Directors may in exceptional circumstances agree that its members can participate in its meetings by video or computer link provided it remains live and uninterrupted. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.26.2. Directors who are unable to attend a meeting should advise the Secretary in advance of the meeting so that their apologies may be submitted.

4.27 **Chair's Ruling** - Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.28 **Voting** - Subject to any legal requirements or any requirements of the Constitution, if in the opinion of the Chair, a vote should be required on a question at the meeting, it shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

4.29 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request or the Chair so direct.

4.30 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.31 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.32 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote, subject to SO 4.26.

4.33 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of temporary incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

4.34 **Minutes** - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it. In accordance with paragraph 30.2, a copy of the minutes, following agreement from the Board, will be made available to the Council of Governors.

4.35 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.36 Minutes shall be circulated in accordance with the Directors' wishes. Where providing a record of a public meeting, the minutes shall be made available to the public.

4.37 **Suspension of Standing Orders** - Except where this would contravene any provision of the Constitution or authorisation or any statutory provision or any direction made by NHS England, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Directors are present. This shall include at least one Executive Director and one Non-Executive Director and a majority of those present vote in favour of suspension.

4.38 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.39 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.40 No formal business may be transacted while SOs are suspended for procedural purposes.

4.41 The Audit Committee shall review every decision of the Board of Directors to suspend SOs.

4.42 **Variation and Amendment of Standing Order**s - These Standing Orders may only be amended in accordance with the Constitution and, in addition, only if:

- A notice of motion under SO 4.20 has been given; and
- No fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and
- At least two-thirds of the Directors are present; and
- The variation proposed does not contravene a statutory provision or direction.

4.43 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

Arrangements for the Exercise of Functions of the Board of Directors by Delegation

5.1. Subject to the Constitution, any legal requirements and such directions as may be given by NHS England, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee of Directors, appointed by virtue of SO 6 or by an Executive Director in each case subject to such restrictions and conditions as the Board thinks fit.

5.2. **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders (SO 3.4) may in emergency be exercised by the Chief Executive and the Chair, after having consulted and obtained the agreement of the Chair and at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for Directors for ratification.

5.3. **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees which it has formally constituted including any joint committees constituted to further joint working arrangements subject to paragraphs 4.6-4.8 of the Constitution). The Constitution and terms of reference of these committees or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

5.4. **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

5.5. The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board of Directors subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.

5.6. Nothing in the Scheme of Delegation shall impair the overall responsibility of the Board of Directors or the discharge of the direct accountability to the Board of Directors of the Chief Executive or other Executive Director to provide information and advise the Board of Directors in accordance with the Constitution, any statutory requirements or any requirements of NHS England.

Committees

6.1. **Appointment of Committees** - Subject to the Constitution and such directions as may be given by NHS England, the Board of Directors may appoint committees of the Board of Directors, consisting wholly of Directors of the Trust.

6.2. A committee appointed under SO 6.1 may, subject to such directions as may be given by NHS England or the Board of Directors appoint sub-committees consisting of Directors of the Trust.

6.3. A committee established pursuant to paragraph 6.2 above may meet in common with a committee of Directors of another NHS Foundation Trust.

6.4. The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board of Directors.

6.5. Each such committee or sub-committee, shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.6. Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

6.7. The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors.

6.8. The Trust is required to establish the following committees of Non-Executive Directors in accordance with the 2006 Act.

- Remuneration (known as Nominations and Remuneration Committee)
- Audit

6.9. The Trust has chosen to establish the following committees of the Board:

- Finance and Performance
- Strategy Transformation and Partnerships
- Quality Governance
- Charitable Funds Committee

6.10. **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

6.11. A Director of the Trust shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

Declarations of Interests and Register of Interests

7.1. **Declaration of Interests** - Directors are required to comply with the Trust's Standards of Business Conduct, to declare interests that are required to be declared by the Constitution and to declare any other interests that are material to the Board of Directors. All Directors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.2. Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or public liability companies (PLCs) (with the exception of those of dormant companies).
b) Ownership or part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
d) A position of authority in a charity or voluntary organisation in the field of health and social care.
e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

7.3. If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or Secretary.

7.4. At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board of Directors meeting following the change occurring. It is the obligation of the Director to inform the Secretary of the Trust in writing within five working days of becoming aware of the existence of a relevant or material interest.

7.5. Board Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.6. During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, the majority will resolve the issue with the Chair having the casting vote.

7.7. There is a requirement for the interests of Directors' spouses or partners to be declared, if they fall within the criteria outlined in SO 7.2.

7.8. **Register of Interests** - In accordance with the Constitution, the Secretary will ensure that a Register of Interests is established to record formal declarations of interests of§ Directors. In particular the Register will include details of all Directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Board Directors, as defined in SO 7.2.

7.9. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.10. The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

Disability of Directors in Proceedings on Account of Pecuniary Interest

8.1. Subject to the provisions of the Constitution and to the following provisions of this Standing Order, if a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2. The Board may exclude a Director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

8.3. For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 8.2 and SO 8.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) They, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) They are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons or persons living together as partners the interest of one or other shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.4. A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;
(b) of an interest in any company, body or person with which they are connected as mentioned in SO 8.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.5. Where a Director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

8.6. Standing Order 8 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a Director) as it applies to a Director.

8.7. **Waiver of Standing Orders made by the Secretary of State for Health -** Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chair or a member of the Board from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which they have a pecuniary interest) should be removed.

Standards of Business Conduct

9.1. **Policy -** All Directors of the Trust shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the Trust.

9.2. **Interest of Directors/Officers in Contracts** - If it comes to the knowledge of a Board Director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

9.3. An officer must also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a member of their family or of someone with whom they have a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. A register of declared interests of staff shall be kept and maintained by means of an annual review.

9.4. **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

9.5. A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

9.6. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

9.7. **Relatives of Directors or Officers** - Candidates for any staff appointment shall, when making application, disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

9.8. The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

9.9. On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office under the Trust.

9.10. Where the relationship of an officer or another Director to a Director of the Trust is disclosed, the Standing Order headed `Disability of Directors in proceedings on account of pecuniary interest' (SO 8) shall apply.

9.11. Relationships to which this order applies are those of father, mother, child, grandchild, brother, sister, aunt, uncle, nephew or niece of the member, their spouses or partners living together.

9.12. **Acceptance of Gifts and Hospitality** - The Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. The central register, held by the Secretary will record all gifts and hospitality accepted.

Resolution of Disputes with Council of Governors

10.1. Should a dispute arise between the Board of Directors and the Council of Governors, then the disputes resolution procedure set out below shall be followed.

10.2. The Chair, or Vice Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

10.3. Failing resolution under 10.2 above, then the Board of Directors or the Council of Governors, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4. The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board of Directors or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5. The Chair or Vice Chair (if the dispute involves the Chair) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.2 above shall be repeated.

10.6. If, in the opinion of the Chair or Vice Chair (if the dispute involves the Chair) and following the further discussions prescribed in 10.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Vice Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and Board of Directors accordingly.

10.7. On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8. On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

10.9. Nothing in this procedure shall prevent the Council of Governors, if it so desires and acting through the Lead Governor, from informing NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors that the Trust is not acting in accordance with the terms of its Constitution or not complying with the terms of the 2006 Act.

Board of Directors' Performance

11.1. The Chair shall, at least annually, lead a performance assessment process for the Board of Directors. This process should act as the basis for determining individual and collective professional development programs for Directors.

Miscellaneous

12.1. **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions in accordance with the Code of Conduct requirements. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

12.2. **Documents having the Standing of Standing Orders** - Standing Financial Instructions and Matters Reserved for the Board and the Scheme of Delegation shall have the effect as if incorporated into SOs.

12.3. **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Trust. Any amendments to these Standing Orders identified by the review must be approved by the Audit Committee and the Board of Directors before being annexed to the Constitution. The requirement for review extends to all documents having the effect as if incorporated in SOs.

12.4. **Indemnity** - A Director, or officer of the Trust, who has acted honestly and in good faith will not have to meet out of their own personal resources any personal civil liability which is incurred in the execution or purported execution of their functions as a Director save where the Director has acted recklessly. Any costs arising in this way will be met by the Trust. On behalf of the Directors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

Custody of Seal and Sealing of Documents

13.1 **Custody of Seal** - the Secretary shall have charge of the Trust's seal which will be kept in a secure place.

13.2 **Sealing of Documents** – As stated in paragraph 43.2 of the Constitution the seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a Committee, where the Board has delegated its powers. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Executive Officer (or an Officer named by them) and authorised and countersigned by the Chair (or an Officer nominated by them who shall not be within the originating directorate).

13.3 **Register of Sealing**- An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings should be made to the Trust via the Audit Committee on an annual basis. (The report shall contain details of the seal number, the description of the document and the date of sealing).

13.4 **Use of Common Seal** - The use of the common seal shall be confined to the purpose outlined below and to such other purposes as may in future be designated by law.

- Contracts made by the Trust as per the Trust's tendering and contract procedure.
- Documents relating to the purchase of stocks and shares in accordance with the Trust's policy on charitable funds.
- Issue of training certificates.
- Any other contracts, indemnity, deed or undertaking, which by law require the use of the Trust's seal.

Annex 8 – Further Provisions relating to members

Disqualification from membership

1. In addition to paragraph 10 of the Constitution, a person may not become a member of the Trust if:

1.1. They have been banned from Trust premises in accordance with the Trust's policy on "Dealing with Violence and Aggression" or prosecuted for criminal or unacceptable behaviour; or
1.2. They have demonstrated unacceptable levels of violent or aggressive behaviour towards staff and/or patients and been subject to an application of the Trust's policy on "Dealing with Violence and Aggression"; or
1.3. They have been declared by the Council of Governors or one of its sub-committees to be a vexatious complainant or where they fail to abide by the Trust's Values.
1.4. They do not agree to (or, having agreed to, fail to abide by) the Trust Values.

2. It is the responsibility of the member to ensure their eligibility and not the Trust, but where the Trust is on notice that a member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

Termination of membership

3. A member shall cease to be a member if:

3.1. They die;
3.2. They resign by notice to the Secretary;
3.3. They cease to be entitled under this Constitution to be a member of the public constituency;
3.4. They are expelled under this Constitution;
3.5. If it appears to the Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a member of the Trust.

4. A member may be expelled by a resolution of the Council of Governors at a General Meeting. The following procedure is to be adopted:

4.1. Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

4.2. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

4.2.1. dismiss the complaint and take no further action; or
4.2.2. arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

4.3. If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

4.4. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

4.5. If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

4.6. A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

4.7. Where a person has been expelled from membership under the provisions of this paragraph, they may submit a written appeal within a 6-month period from the expulsion to the Secretary. A Chair of another foundation trust will be appointed to consider the appeal and their decision on the matter will be final.

4.8. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a General Meeting.

Commitments

5. Representative membership

5.1. The Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

5.1.1. the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years,

5.1.2. the Council of Governors shall present to each annual members' meeting a report on:

5.1.2.1. steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the Staff Constituency is representative of those eligible for such membership;

5.1.2.2. the progress of the membership strategy;

5.1.2.3. any changes to the membership strategy.

Openness

5.2. In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting distribution

5.3. The profits or surpluses of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

Framework

5.4. The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this Constitution and the Trust's NHS provider licence. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this Constitution.

Members

5.5. Members may attend and participate at members' meetings, vote in elections to, and, if eligible, stand for election to, the Council of Governors, and take such other part in the affairs of the Trust as is provided in this Constitution.

Dispute resolution procedures

5.6. In the event of a dispute with a member or applicant in relation to matters of eligibility and disqualification, such member or applicant shall be invited to discuss the grounds of dispute with the Secretary, in the first instance. If not resolved, the issue will be submitted to an arbitrator agreed by the parties. The arbitrator's decision will be binding and conclusion on all parties.

5.7. Any person bringing a dispute must, if required to do so, deposit with the Trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

Annex 9 – Annual Members' Meeting

1. The Trust is to hold a members' meeting (the "Annual Members' Meeting") within nine months of the end of each financial year. All members' meetings other than annual meetings are called special members' meetings and shall, insofar as possible, follow the requirements and provisions of this Annex.

2. Members' meetings are open to all members of the Trust, Governors and Directors, representatives of the Trust's financial auditor and to the public. The Council of Governors may invite representatives of the media, and any experts or advisors, whose attendance they consider to be in the best interests of the Trust to attend the Annual Members' Meeting.

3. The Annual Members' Meeting is to be convened by the Secretary by order of the Council of Governors. The Trust may, if agreed by at least half of the whole of the Council of Governors, combine the Annual Members' Meeting with the Council of Governors' meeting which is held for the purpose of considering the Trust's Annual Report and Accounts.

4. The Council of Governors may decide where an Annual Members' Meeting is to be held and may also for the benefit of members arrange for the Annual Members' Meeting to be held in different venues each year.

5. At the Annual Members' Meeting, the Board of Directors shall present to the members:

5.1. the annual accounts
5.2. any report of the financial auditor
5.3. any report of any other external auditor of the Trust's affairs
5.4. forward planning information for the next financial year;

6. The Council of Governors shall present to the members:

6.1. a report on steps taken to secure that (taken as a whole) the actual membership of its public and staff constituencies is representative of those eligible for such membership;
6.2. the progress of the membership strategy
6.3. any proposed changes to the policy for the composition of the Council of Governors and of the Non-Executive Directors
6.4. the results of any election and appointment of Governors and the appointment of Non- Executive Directors will be announced.

7. Notice of the Annual Members' Meeting is to be given:

7.1. by notice to all members;
7.2. by notice prominently displayed at the head office and at all of the Trust's places of business; and
7.3. by notice on the Trust's website;
7.4. at least 14 working days before the date of the meeting.

8. The notice must:

8.1. be given to the Council of Governors and the Board of Directors, and to the financial auditor;
8.2. give the time, date and place of the meeting; and
8.3. indicate the business to be dealt with at the meeting.

9. Before an Annual Members' Meeting can do business there must be a quorum present. Except where this Constitution says otherwise a quorum is one member present from each of the Trust's constituencies.

10. Subject to the requirements of the Constitution, the Trust may make arrangements for members to vote by post, or by using electronic communications.

11. It is the responsibility of the Council of Governors, the Chair of the meeting and the Secretary to ensure that at the Annual Members' Meeting:

11.1. the issues to be decided are clearly explained;

11.2. sufficient information is provided to members to enable rational discussion to take place.

12. The Chair of the Trust, or in their absence the Vice Chair of the Trust, or in their absence one of the other Non-Executive Directors shall preside at all members' meetings of the Trust. If neither the Chair nor the Vice Chair, nor any other Non-Executive Directors are present, the meeting shall be adjourned to such time and place as the Chair may subsequently determine.

13. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

14. A resolution put to the vote at a members' meeting shall be decided upon by a poll.

15. Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second or casting vote.

16. The result of any vote will be declared by the Chair and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

Annex 10 – Election Rules

(Paragraph 13.2)

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Part 1 - Interpretation

Interpretation

1.1 In these rules, unless the context otherwise requires:
"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this Constitution;

"*Council of Governors*" means the Council of Governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"e-voting" means voting using either the internet, telephone or text message;

"e-voting information" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead Governor*" means the Governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (NHS England, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*NHS England*" means the corporate body known as NHS England as provided by section 61 of the 2012 Act, which operates with the National Health Service Trust Development Authority as NHS Improvement.";

"*numerical voting code*" has the meaning set out in rule 57.2(b) "*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2; "*telephone voting record*" has the meaning set out in rule 26.5 (d); "*text message voting facility*" has the meaning set out in rule 26.3; "*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding		**Time**
Publication of notice of election		Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer		Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates		Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notice of withdrawals by candidates from election		Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll		Not later than the fifteenth day before the day of the close of the poll.
Close of the poll		By 5.00pm on the final day of the election.

Computation of time

3.1 In computing any period of time for the purposes of the timetable:
(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,
shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

Returning officer

4.1 Subject to rule 62, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

Staff

5.1 Subject to rule 62, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

Expenditure

6.1 The corporation is to pay the returning officer:
- a) any expenses incurred by that officer in the exercise of their functions under these rules,
- b) such remuneration and other expenses as the corporation may determine.

Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of their functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

Notice of election

8.1 The returning officer is to publish a notice of the election stating:
- a) the constituency, or class within a constituency, for which the election is being held,
- b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
- c) the details of any nomination committee that has been established by the corporation,
- d) the address and times at which nomination forms may be obtained;
- e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address or such return) and the date and time by which they must be received by the returning officer,
- f) the date and time by which any notice of withdrawal must be received by the returning officer,
- g) the contact details of the returning officer, and
- h) the date and time of the close of the poll in the event of a contest.

Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:
- a) is to supply any member of the corporation with a nomination form, and
- b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

Candidate's particulars

11.1 The nomination form must state the candidate's:
- a) full name
- b) contact address in full (which should be postal address although an e-mail address may also be provided for the purpose of the electronic communication), and
- c) constituency, or class within a constituency, of which the candidate is a member.

Declaration of interests

11.1 The nomination paper must state:
- a) any financial interest that the candidate has in the corporation, and
- b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the form must include a statement to that effect.

Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:
- a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and
- b) for a member of the public constituency of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
- a) they wish to stand as a candidate,
- b) their declaration of interests as required under rule 11, is true and correct, and
- c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
- a) decides that the candidate is not eligible to stand,
- b) decides that the nomination paper is invalid,
- c) receives satisfactory proof that the candidate has died, or
- d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:
- a) that the form is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
- b) that the form does not contain the candidate's particulars, as required by rule 10;
- c) that the form does not contain a declaration of the interests of the candidate, as required by rule 11,
- (d) that the form does not include a declaration of eligibility as required by rule 12, or
- (e) that the form is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an email address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

b) the declared interests of each candidate standing, as given in their nomination form

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statements of candidates or their nomination forms, the corporation is to provide that person with the copy or extract free of charge.

Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him in consultation with the corporation.

Part 5 – Contested elections

Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
   (i) configured in accordance with these rules; and
   (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
   (i) configured in accordance with these rules; and
   (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
   (i) configured in accordance with these rules; and
   (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she or she has not marked or returned any other voting paper in the election, and

(c) the particulars of their qualification to vote as a member of the constituency or class within the constituency or which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return their declaration of identity with their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:
(a) a postal address; and,
(b) the members email address, if this has been provided
to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

Issue of voting documents by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the corporation named in the list of eligible voters:
(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required)
(c) information about each candidate standing for election, pursuant to rule 54 of these rules, and
(d) a covering envelope.

("postal voting information")

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 57 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
(d) contact details of the returning officer.

("e-voting information")

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
- (i) enter his or her voter ID number; and
- (ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) specify:
- (i) the name of the corporation,
- (ii) the constituency, or class within a constituency, for which the election is being held,
- (iii) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
- (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (v) instructions on how to vote and how to make a declaration of identity,
- (vi) the date and time of the close of the poll, and
- (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
- (i) the voter’s voter ID number;
- (ii) the voter’s declaration of identity (where required);
- (iii) the candidate or candidates for whom the voter has voted; and
- (iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to
- (i) enter his voter ID number in order to be able to cast his or her vote; and
- (ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:
- (i) the name of the corporation,
- (ii) the constituency, or class within a constituency, for which the election is being held,
- (iii) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
- (iv) instructions on how to vote and how to make a declaration of identity,
- (v) the date and time of the close of the poll, and
- (vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
- (i) the voter's voter ID number;
- (ii) the voter's declaration of identity (where required);
- (iii) the candidate or candidates for whom the voter has voted; and
- (iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
- (i) provide his or her voter ID number; and
- (ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
- (i) the voter's voter ID number;
- (ii) the voter's declaration of identity (where required);
- (ii) the candidate or candidates for whom the voter has voted; and
- (iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e)

(f) prevent any voter from voting after the close of poll.

The poll

Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:
(a) is satisfied as to the voter's identity, and
(a) has ensured that the completed ID declaration form , if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):
(a) the name of the voter, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):
(a) the name of the voter, and
(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
(c) the details of the replacement voter ID number issued to the voter.

Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:
(a) is satisfied as to the voter's identity,
(b) has no reason to doubt that the voter did not receive the original voting information,
(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):
(a) the name of the voter, and
(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity

Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

Receipt of voting documents

36.1 Where the returning officer receives a:
(a) covering envelope, or
(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,
before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed, and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:
(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form, accompanying the ballot paper, mark it as "disqualified" and attach it the ballot paper,
(c) record the unique identifier on the ballot paper in a list (the "list of disqualified documents"); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

Declaration of identity but no ballot paper (public and patient constituency)

38.1 Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to:
(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and
(c) place the ID declaration form, in a separate packet.

De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declarations forms if required,
(c) the list of spoilt ballot papers,
(d) the list of lost ballot papers,
(e) the list of eligible voters, and
(f) the list of tendered ballot papers.

Part 6 - Counting the votes

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:
"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.
"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:
(a) on which no second or subsequent preference is recorded for a continuing candidate, or
(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:
(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:
(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of Directors and the council of Governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

The count

43.1 The returning officer is to:

(a) count and record the number of :

(i) ballot papers that have been returned, and

(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 41.2(ii) where vote counting software is being used

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty, shall, subject to rules 43.2 and 43.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:
(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:
(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules 43.2 and 43.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:
(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:
(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty, shall, subject to rules 43.7 and 43.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:
(a) otherwise than by means of a clear mark,
(b) by more than one mark,
is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:
(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules 43.7 and 43.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:
(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,
and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub- parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub- parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:
(a) a transfer value calculated as set out in rule STV47.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred,
whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:
(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:
(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:
(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub- parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:
(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV50, one or more vacancies remain to be filled,
the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:
(a) ballot documents on which a next available preference is given, and
(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub- parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he or she has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
  (i) the total value of votes, or
  (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non- transferable votes total, and
(d) compare:
  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51 Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

FPP52 Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the Council of Governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she or she has declared elected:

(i) where the election is held under a proposed Constitution pursuant to powers conferred on Dorset County Hospital NHS Foundation Trust by section 33(4) of the 2003 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule 43.5,

(c) the number of rejected text voting records under each of the headings in rule 43.10 available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed Constitution pursuant to powers conferred on the Dorset County Hospital NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3, available on request.

Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting papers endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records.

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage

54.2 The returning officer must not open the sealed packets of:
(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,
or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49 , the returning officer is to forward them to the chair of the corporation.

Forwarding of documents received after close of the poll

56.1 Where:
(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new ballot papers to be issued,
the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 51.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

Application for inspection of certain documents relating to an election

58.1 The corporation may not allow
(a) the inspection of, or the opening of any sealed packet containing –
(i) any rejected ballot papers, including ballot papers rejected in part,
(ii) any rejected text voting records, including text voting records rejected in part,
(iii) any disqualified documents, or the list of disqualified documents,
(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
(v) the list of eligible voters

(b) Access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage by any person without the consent of the regulator.

58.2 A person may apply to the regulator to inspect any of the documents listed in rule 51.1 and the board of Directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of Directors of the corporations consent may be on any terms or conditions that it thinks necessary, including conditions as to:
(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,
and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed rule 51.1 the board of Directors of the corporation must:
(a) in giving its consent, , and
(b) in making the documents available for inspection, ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:
(i) that his or her vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to
(a) countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule 52.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under paragraph (52.1)(a), paragraphs (52.4) to (52.7) are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:
(a) count and record the number of ballot papers that have been received, and
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complex electronic copies of the internet voting records telephone voting records and text voting records crated in accordance with rule 26 are held in a device suitable or the purpose of storage,

FPP59.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs (52.4) to (57.6), the returning officer is to deliver them to the Chair of the corporation, and rules 50 and 51 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Part 10 – Election expenses and publicity

Election expenses

Election Expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

Election expenses incurred by other persons

62.1 No person may:
(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 56 and 57.

Publicity

Publicity about election by the corporation

63.1 The corporation may:
(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,
as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 57, must be:
(a) objective, balanced and fair,
(b) (as far as the information provided by the candidates so allows) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words, and
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
(c) a photograph of the candidate if supplied by the candidate.

Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS England or the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS England by:
(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:
(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the regulator may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS England will refer the application to the independent election arbitration panel appointed by NHS England.

66.6 If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS England shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application, including costs.

Part 12 – Miscellaneous

Secrecy

67.1 The following persons:
(e) the returning officer,
(f) the returning officer's staff,
must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
(i) the name of any member of the corporation who has or has not been given a ballot paper or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:
(a) a member of the corporation,
(b) an employee of the corporation,
(c) a Director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:
(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers and declarations of identity,
the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ICB Board Report

Reporting Committee:	ICB Board
Date of Meeting:	16 January 2025
Meeting Chair:	Jenni Douglas Todd, ICB Chair

Decisions made by the Board	• The Board approved the proposed amendments to the NHS Dorset Constitution in line with the revised model constitution released by NHS England. The Board also approved the amendments to the Standards of Business Conduct Policy, Scheme of Reservation and Delegation and committee Terms of Reference. Updates to governance documents contained within the ICB'S Governance Handbook were noted.
Key Messages agreed by the Board	• The Board welcomed the deep dive on improving outcomes in population health, considering the greatest opportunities to improve population health and what the system should focus on, including secondary prevention, reducing inequalities, increasing physical activity and wider determinants of health. • Noted the challenges relating to winter pressures: although there had been a peak in activity between Christmas and New Year the position had largely been recovered (other than for No Criteria to Reside) demonstrating that the winter plan was helping to mitigate the winter challenges. • Reiterated the importance of, and our commitment to, the work on frailty and falls, and that this work would be monitored through the ICB Prevention, Equity and Outcomes Committee. • Noted quality, operational and financial performance, welcoming position performance in relation to 65 week waiters, ambulance performance and Elective Recovery Funding. • Noted the formal move to a £25 million variance to plan, resulting in a revised forecast outturn of a £45m deficit for 2024/25, and considered the potential impacts of Personal Health Commissioning, transformation work and Integrated Neighbourhood Teams. • Welcomed the Healthwatch report into homelessness and health, especially the opportunity to hear citizens' voices through the report. In response to the ICB's proposed action plan, it was agreed that as this work moved forward it was vital to collaborate with partners, especially the local authorities and voluntary sector, and that pace, culture and sustainability were of key importance. • The Board said goodbye to Matt Prosser, CEO at Dorset Council, and thanked him for all his work for the residents of Dorset and the Integrated Care System.

Summary of items received by the Board	• Board Story and Deep Dive on the core purpose of improving outcomes in population health and healthcare • Board Assurance Framework • Chief Executive Officer's Report • Committee Escalation Reports • Dorset NHS Financial Recovery Plan 2024-25 • Annual Review of Governance Arrangements • ICB Homeless Health Plan

Report to	Board of Directors	
Date of Meeting	8th April 2025	
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 2024 – Dec 2024)**	
Prepared By	Dr Jill McCormick, Guardian of Safe Working	
Accountable Executive	Dr Rachel Wharton, Chief Medical Officer	
Previously Considered By	Submission to People and Culture Committee approved by Alastair Hutchison People and Culture Committee in Common	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Relates to Board Assurance Framework: SR1: Safety and Quality SR2: Culture SR3: Workforce Capacity The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.	
Financial		
Statutory & Regulatory	Adhering to requirements of the Junior Doctor Contract 2016	
Equality, Diversity & Inclusion	People Plan Principle – we will improve safety and care by creating a culture of openness, innovation, and learning, where staff feel safe themselves	
Co-production & Partnership	The report is also shared with the Local Negotiating Committee for Medical and Dental staff once seen by PCC.	

Executive Summary

Executive summary

1. The is the Q3 Report submitted to the Trust Board by the Guardian of Safe Working, dates from 01/10/2024 – 31/12/2024
2. There is continued support from educational supervisors towards supporting the Exception Reporting system, when clinical need has demanded Resident Doctors work outside of their contractual role.
3. During this period of time there were 64 Exception reports received, 3 were Immediate Safety Concerns (ISC). The majority were related to hours of working (45 in total), 5 relating to the pattern of work, 9 regarding educational opportunities and 5 related to service support available.
4. The Immediate Safety Concern (ISC) were only 3 during this period relating to understaffing in T&O, with 21 ERs in total within this area. Ongoing discussions for solutions, including a business case for an Ortho-Geriatric Middle Grade, and an escalation pathway.

Recommendation
The Board is requested to: • Receive the report for **assurance**

Title of Meeting	**Joint People and Culture Committee in Common**
Date of Meeting	**24 March 2025**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (1st Oct 2024 – 31st Dec 2024)**
Author	**Dr Jill McCormick, Guardian of Safe Working (GoSW)**

Executive summary

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Introduction

All eligible doctors in training between April and June 2024 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract") and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW).

All work schedules provided to doctors in training within 2024 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

High level data for Dorset County Hospital NHS trust

Number of training post (total): 202

Number of doctors in training post (total): 185.1

Annual average vacancy rate among this staff group: 17.9

Amount of time available in job plan for Guardian of Safe Working 1 PA

Amount of job planned time for educational supervisor 0.25 PA per trainee

Exception reports

Exception reports by department				
Specialty	No. exceptions carried over from last report (Q2)	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (from Dec '24)
Acute Medicine	6	1	1	0
Anaesthetics	1	0	0	0
Dermatology	1	1	0	1
D&E	0	2	0	2
ENT	5	4	4	0
Gastroenterology	0	1	0	1
General Medicine	1	3	2	1
General Practice	1	2	0	2
Geriatric Medicine	6	18	12	6
Haematology	0	4	3	1
Obstetrics & Gynaecology	3	1	1	0
Renal	0	3	1	2
Respiratory Medicine	1	2	2	0
Trauma & Orthopaedics	11	21 (3 ISC)	20	1
Urology	1	1	1	0
Total	37	64 (3 ISC)	47	17

Exception reports by grade				
Grade	No. exceptions carried over from last report (Q2)	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (from Dec'24)
F1	20	36	29	7
F2	10	11	7	4
CT3	0	3	2	1
ST1	5	8	6	2
ST3	1	6	3	3
ST4	1	0	0	0
Total	37	64	47	17

Exception reports (response time) *this is a formal requirement of the annual report*			
	Addressed within 48 hours	Addressed within 7 days	**Addressed in longer than 7 days**
CT1	0	0	0
CT3	3	0	0
F1	4	5	27
F2	2	1	8
ST1	0	1	7
ST3	0	3	3
ST4	0	0	0
Total	9	10	45

Work schedule reviews

Upon the submission of an Exception Report that suggests a mismatch between a junior doctor's work schedule and the actual clinical demands required in that post, it is the responsibility of that doctor's educational supervisor to trigger a *Level 1 (Work Schedule) Review*. Example outcomes of such a review include no requirement for change, a prospective requirement to adjust existing work schedules, or even institutional change. The Exception Report is closed at Level 1 if the junior doctor and educational supervisor agree an outcome, or escalated to *Level 2 Review* (with involvement of Guardian/DME and service management) if the junior doctor is not in agreement with the outcome. *Level 3 Review* constitutes a formal grievance hearing with HR representation.

Exception Reports taken to Level 1 Work Schedule Review

Specialty	**ST3**	**F2**
Haem	3	
ENT		1
Resp		1
Total	**3**	**2**

Rota	**Total**

2024 F2 Surgical 07/08/24-03/12/24	**1**
2024 F2 MED 07/08/2024 - 03/12/2024	**1**
2024 STR GASTRO - Med 04/09/2024 - 02/09/2025	**3**
Total	**5**

Vacancies

Appendix 1 Details all vacancies among the medical training grades during the Q3 of this year, split by specialty and grade.
Appendix 2 – Exception report submission since 2023/4 until Q3 of 2024/5
Appendix 3 – Exception report submission since 2016 – 2023/2024

Fines

There were no fines levied during this period.

Qualitative information

Part of overseeing the Exception Reporting mechanism involves a constant awareness of under reporting and a constant effort to promote appropriate engagement with the mechanism via the Medical Director, DME, GoSW, GMC regional officer and the local BMA representatives.

Within the Q3 Report there were 64 Exception Reports. 3 were Immediate Safety Concerns (ISC), 45 related to hours of working, 9 related to education opportunities, 5 related to the pattern of work, and 5 related to service support available to a doctor.

Resolutions (within this period) have been 51 in total with 17 TOIL (Time in lieu), 37 overtime payments, 1 work schedule review, 17 unresolved and 4 resulting in no action.

Within the Immediate Safety Concerns

There were 3 ISCs within this period of time, all came within the Trauma & Orthopaedics department. 2 reports from the same RD and 1 other report, both Resident Doctors are FY1s.

(1) Understaffing on ward and unsafe levels. Another FY1 was pulled to help cover.
(2) During a weekend the FY1 ward cover was alone, as the on-call SHO ward cover was off sick, and this doctor felt she had to do both jobs. There was a locum advertised at a standard rate, but unfilled, concern over unsafe staffing levels. However discussed with Supervisor that there was also an on-call SpR / SHO on site to help. Closed unresolved.

(3) Patient safety concern due to unsafe staffing levels, due to sickness, FY1 and locum SHO on the ward. Closed unresolved

I have gone through each report individually. Most ERs came from the most junior Resident Doctors, FY1 / FY2 and occasionally CT3 /ST1/ST3. It is definitely worth noting from the table above of 'Exception reports by department', it is an inaccurate reflection of data which we will need to amend going forward and capture differently. Within the ER from each individual there is the 'Rota Group' and, 'Specialty' , the narrative and concern within each ER is not necessarily related to the specialty the RD is currently working in. This is particularly important when considering the large number of Geriatric ERs, which is mis-leading, and in fact they have far fewer than this. Dermatology in fact had no ER, it was related to a T&O on-call.

Below I have gone through each concerning area, and some of the narrative from each.

T&O Exception Reports

General theme is staying late during on call shifts or day shifts for a variety of reasons including unavoidable emergencies, exceptionally busy on-calls, large quantities of patients, complicated discharges, and lengthy referrals (to Salisbury spinal team). Most are staying late for 1 hour, on occasion 2 hours. There is also mention of understaffing, particularly within the ISCs and pulling in other FY1 doctors to help cover from other areas.

During this 4 months rotation due to RDs staying over the original on-call time of 0800 – 1600 by an extra hour, it was extended from 0800 – 1700 as a normal working day with a change in rota.

The Orthopaedic FY1 work schedule for 3 x RDs (from August 2024 – December 2024) was non EWTD compliant and they have been financially compensated when this was realised.

I don't necessarily think the ERs for T&O encapsulates fully the demands for a FY1/FY2 RD on the ward and support. Really they do need more senior support to manage these complex patients, and where they can from Orthopaedic SpRs / Consultants, and also Ortho-Geriatricians. However it has been proposed a Ortho-Geriatric Middle grade would be of additional benefit, and a business case is in preparation for this discussion, which I would fully support. In terms of safety for patients there is a proposed escalation plan for medical concerns and ongoing discussions with FY2 Programme director and DME, as to support for FY1/FY2 doctors with Orthopaedics.

Diabetes/Endocrine (2 ERs): Staying late for 1 hour and a missed educational opportunity (offered to watch online and take 1 hour back in lieu if occurred in working time).

Medicine Exception Reports

As mentioned many of the 'Geriatric Reports' are actually with regards to Medical On-call, it is the Specialty the RD is attached to during that rotation.

Examples from the ERs

- 30/12 extreme pressure in hospital and stayed 1.5 hours (1300 – 0130)

- On 27/12 during a Bank Holiday On-call, FY1 swamped with very high work load (ward cover for medicine), and unable to reach ST3+/ med registrar for review.
- During a medical on-call 1700 – 1200 FY1 finished at 0130. FY1 didn't feel able to handover and go home, however this was discussed that handover is important if patient is not critically unwell.
- Further 3 ERs relating to staying late during a Medical On-call between 1-3 hours after the shift 1700 – 0000 hrs.

There is a new meeting which commenced on 15th January 2025, which involved senior medical SpRs, senior medical consultants, and GOSW to discuss issues within medicine, and will be a good forum to raise issues such as on-call and reflect on these detailed ERs. However within changes to medical Rota**,** there are now 2 SHOs overnight (FY2 and above), and 1 SpR (which is an increase from 1 SHO and 1 SpR), which should hopefully improve the on-call work load / ward cover overnight.

Looking through ERs for Geriatrics

- Understaffed on the wards (from 3 ERs)
- Other areas were relating to staying from clinical reasons such as review of an unwitnessed fall, Stay 45 mins extra due to unwitnessed falls

General Practice reporting: Only 2 reports for working an extra 30 mins over time (for unavoidable reasons). This needs another communication to GP trainers / and GP SpRs to bring awareness to the Exception reporting system.

Haematology – No SHO (FY1/FY2/IMT) cover for 4 days (SpR covered ward with other contractual duties).

Renal – 3 ER. Two reports due to short staff on the ward and staying later 45 mins and 1.5 hours. Another report due to a very unwell patient and then staying an extra 2.5 hours to finish day jobs. Staying late on the ward.

ENT – 2 ERs reports relating to educational opportunities. Due to on-call, night shifts, only 26 days in a 4 month rotation were on actual ENT, and thought this is not enough time for learning by the RD.

Within the reports there are RDs staying later due to sudden unwell patients, which will always be part of Hospital / General Practice working days, however where an ER has been submitted they are given TOIL or payments appropriately, this will become more automatic in future (as part of the Resident Doctors New Contract).

Resident Doctor Forum points of discussion

- Abbotsbury Resident Doctors office space remains an ongoing issue. RD don't have sufficient working space in this area, lack of computers, or a private area to have family discussions. There was a lot of passion from the RDs how upsetting this issue is for them with day to day practice. There are planned meetings with Stuart Coalwood imminently to further address this issue.

1. Summary

The Guardian acknowledges the Trust's compliance with the safeguarding aspects of the 2016 Contract; recognises good practice within the Trust and a concerted effort to support Resident Doctors' as much as possible.

2. Recommendations

The Guardian asks the committee to note this quarterly report, considering it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract and approve its submission to the Trust Board.

APPENDICES

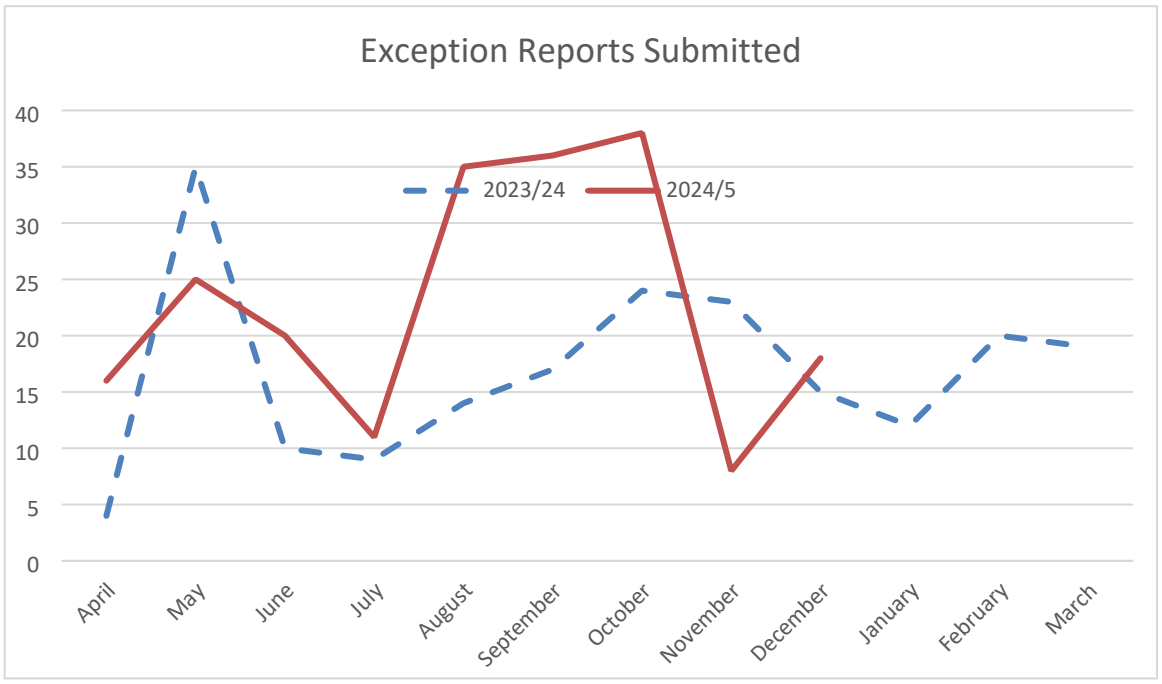
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

OCTOBER 24 – DECEMBER 24

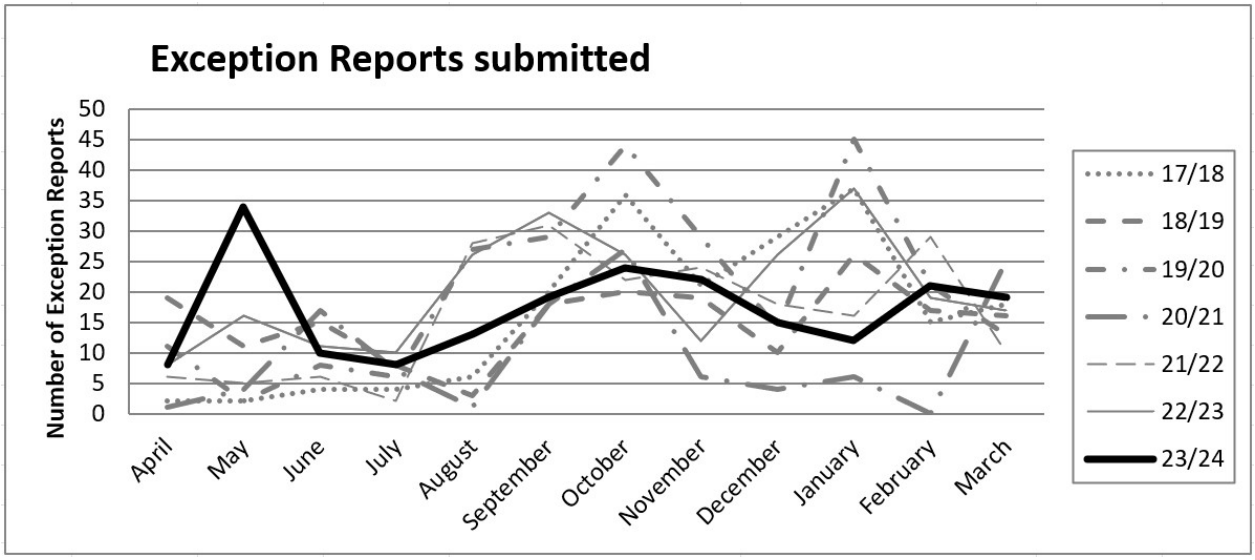
Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Oct 24	Nov 24	Dec 24	Average Q3
Paediatrics	ST3	Sept	0.2	0.2	0.2	0.2
Paediatrics	ST4+	Sept	1	1	1	1.0
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	0	0	0	0.0
ED	ST3+	Sept and Feb	0	0	0	0.0
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	0	0	0	0.0
Surgery	ST3+	Oct	0	0	0	0.0
Orthopaedics	ST3+	Sept	1	1	1	1.0
Anaesthetics	CT1/2	Aug	1.4	2.2	2.2	1.9
Anaesthetics	ST3+	Aug and Feb	0	1	1	0.7
Clinical Radiology	ST1/2	Aug and Feb	0	0	0	0.0
Medicine	CT1/2	Aug	4.1	4.1	4.1	4.1
Medicine COE	ST3+	March	1.2	1.2	1.2	1.2
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	0	0	0	0.0
Medicine Resp	ST3+	Aug	0	0	0	0.0
Medicine Cardio	ST3+	Feb	0.2	0.2	0.2	0.2
Medicine Acute Internal	ST3+	Sept	0	0	0	0.0
Medicine Renal	ST3+	Aug	2	2	2	2.0
Haematology	ST3+	Sept	1	1	1	1.0
Med/Surg	FY1	Aug	2	2	2	2.0
Med/Surg	FY2	Aug	2.9	1.9	1.9	2.2
GPST	ST1	Aug & Feb	0.4	0.4	0.4	0.4
GPST	ST2	Aug & Feb	0	0	0	0.0
GPST	ST3	Aug & Feb	0	0	0	0.0
Orthodontics	ST3+	March	0	0	0	0.0
Ophthalmology	ST3	Aug	0	0	0	0.0
Total			18.4	19.2	19.2	18.9

Appendix 2 – Exception Report submission since 2023/24 to Q3 2024/2025



Appendix 3 – Exception Report submission since introduction of the 2016 Contract to 2023/2024



Dorset County Hospital
Dorset HealthCare

Report to	*Board of Directors*	
Date of Meeting	Dorset County Hospital (DCH) – 8 April 2025 Dorset Healthcare (DHC)– 9 April 2025	
Report Title	Joint Enabling Plans: Clinical and Quality; Infrastructure; Finance, and People	
Prepared By	Emma Booker – Project Manager, Transformation & Improvement Helena Posnett - Consultant in Public Health and DHC Lead for Health Inequalities - Clinical and Quality Plan David Mclaughlin - Joint Director of Estates & Facilities and Tristan Chapman - Director of Strategic Estates – Infrastructure Plan Claire Abraham - Deputy Financial Officer (DCH) and Sarah Day Deputy Financial Officer (DHC) - Finance Plan Sally Northeast - Associate Director, Communications and Public Engagement and Gemma Shone - Projects and Business Manager (DHC) – People Plan	
Approved by Accountable Executive	Dawn Dawson – Joint Chief Nursing Officer and Lucy Knight - Chief Medical Officer (DHC) – Clinical and Quality Plan Chris Hearn - Joint Chief Finance Officer – Infrastructure and Finance Plans Nicola Plumb – Joint Chief People Officer – People Plan	
Previously Considered By	Clinical and Quality Plan – DCH and DHC Quality Committees – 25 and 26 March 2025, approved for circulation to Board Infrastructure and Finance Plans – Finance and Performance Committee in Common (CIC) - 24 March 2025, approved for circulation to Board People Plan – People and Culture CIC -24 March 2025, for further discussion at next informal People and Culture CIC - 23 April 2025 Progress Update on Plans to STP CIC – 26 March 2025 – no action	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Safety and Quality SR2: Culture SR3: Workforce Capacity SR4: Capacity and Demand SR5: Estates SR6: Finance SR7: Collaboration SR8: Transformation and Improvement	
Financial	Cost saving and avoidance by collaborative working and economies of scale.	

Statutory & Regulatory	Increase in compliance on a number of Statutory regulations, including, Health & Social Care Act 2022, Healthcare Technical Memoranda, Health Building Notes, CQC Regulations and the National Standards in soft facilities areas.
Equality, Diversity & Inclusion	Improvement of quality of the environment for all and the provision of further keyworker housing.
Co-production & Partnership	The development of joint plans has enabled co-production and partnership working to grow and be promoted across the federation.

Executive Summary

Following the agreement for DHC and DHC to become federated organisations, planning began in October 2023 to develop a Joint Strategy which would set clear, joint strategic objectives for the Trusts to deliver.
The joint Strategy was published in September 2024 and implementation planning highlighted four key areas:

- 5 Enabling Plans
- Joint Improvement Framework
- One Transformation Approach
- Underpinned by a Culture, Comms and Engagement Plan

The joint strategy will be delivered through five enabling plans. Each enabling plan will support the Trusts in translating the strategic objectives into meaningful action. Each plan has the option to develop an annual plan to enable iteration.

The five Enabling Plans are:

- Clinical & Quality
- Infrastructure
- People
- Finance
- Digital

Leads for each plan were nominated and an approach was agreed which saw all plans develop to the same timeline. Benefits of this approach include read across, the ability to discuss contributions to the objectives and opportunity to combine engagement where this made sense. Each plan has been developed with SRO support and sign-off and as such, each committee will own its plan.

The scope for the digital plan has changed and this work now forms part of the wider ICS Digital Strategy. It has continued to inform the development of the other four plans but is not included within this paper.

The Joint People Plan was presented to the People and Culture CIC on 24 March 2025. Further details around how the plan will be measured and delivered were requested before approval. The plan will be taken to the informal People and Culture CIC on 23 April 2025 for further discussion/approval.

This paper presents the following proposed plans:

Joint Clinical and Quality Plan:

The plan describes the context, alignment to the Joint Strategy, and themes from conversations with staff; and presents the following:

1)10 Clinical and Quality Priorities
2) Clinical Transformation Framework

It was presented to DCH and DHC Quality Committees on 25/26 March 2025 receiving approval with minor changes.

Joint Infrastructure Plan:

The Infrastructure Enabling Plan incorporates the Estates and Facilities (E&F) Transformation Programme and the development of a Joint Infrastructure Strategy for DHC and DCH.

It was presented to the Finance and Performance CIC on 24 March 2025, receiving approval with no changes.

Joint Finance Plan:

The Plan includes finance and procurement and has three priorities:

1) Achieving financial sustainability
2) Strong financial governance
3) Supporting and developing our staff

Presented to the Finance and Performance CIC on 24 March 2025. Noted and approved.

The Board is asked to consider these Plans for approval.

Subject to Board approval, next steps include:

- Handover to the Communications Team to complete edits across all plans, ensuring consistency in language and structure.
- Communications Team to complete design work, ensuring a similar look to the Joint Strategy
- All plans to be published on Trust Intranet sites, with supporting Trust wide comms to be shared
- Move to delivery

Each sub-committee will have ownership for the delivery of their enabling plan, and progress for each individual plan will be reported through its sub-committee. As part of the overarching Joint Strategy reporting, the Strategy, Transformation and Partnerships Committee in Common will maintain oversight of how the plans are delivering, with reach across to each committee as required for assurance of progress.

Recommendation

Board are requested to:

- **Approve** the enabling plans presented

Estates and Facilities Enabling Plan

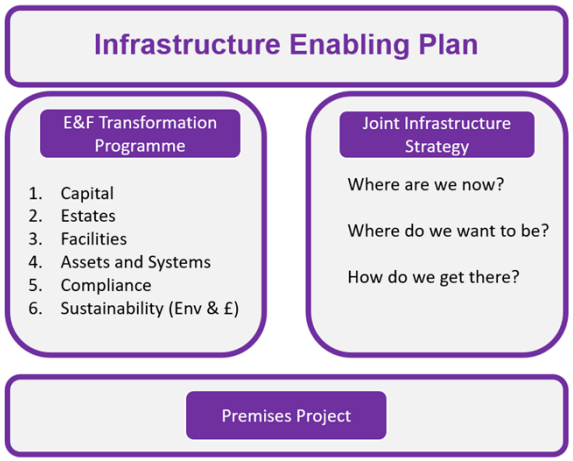
1 Enabling Plan – Infrastructure

1. Introduction

The Infrastructure Enabling Plan incorporates the Estates and Facilities (E&F) Transformation Programme and the development of a Joint Infrastructure Strategy for Dorset Healthcare (DHC) and Dorset County Hospital (DCH) NHS Trusts. The E&F Transformation programme will bring together the Estates and Facilities functions from across the federation to deliver benefits associated with Shared Services. The E&F Transformation Programme will deliver benefits in the 2025/26 financial year. The joint Infrastructure Strategy will be developed in 2025 and cover 5 years, until 2030.

The six key aspects of the E&F Transformation Plan are set out in the diagram below. Led by Joint Director of Estates David McLaughlin, the plan reviews all the areas of Capital, Estates, Facilities Management and Property Management to identify areas where the two Trusts could generate efficiencies whilst maintaining or improving the quality and environmental sustainability of the working environments, Clinical and non-clinical. These efficiencies may be in sharing contracts, services or specialist knowledge.

The Estates teams maintain the built environment, and the facilities teams deliver patient and staff facing services across the estate, whilst the property management teams acquire, lease and dispose of assets to meet the operational strategies in place.



The joint infrastructure strategy will follow the NHS England prescribed approach and will build on the Dorset wide Infrastructure Strategy published in 2024. Led by Strategic Estates Programme Director Tristan Chapman, the plan will incorporate all land and buildings owned and leased by both Trusts, including any car parking, back-up generators and grounds.

Strategic Context

2.1 National Picture

The next NHS 10 year plan is expected to be published in Spring 2025. The goals are:

1. **Shift from treating sickness to preventing illness**: This involves focusing on preventive measures, such as vaccination programs and technologies that help people manage their own health, to reduce the incidence of diseases.
2. **Deliver care closer to home**: The plan emphasizes providing care in communities and primary care settings rather than hospitals, making healthcare more accessible and convenient.
3. **Digital transformation**: Leveraging digital technologies to improve service delivery, enhance patient experience, and ensure better health outcomes.

Our infrastructure enabling plan will respond to these priorities and provide an estate which supports delivery of constitutional NHS standards. Trust staff need to operate from buildings that support the quality and safety of patient services. They must meet statutory obligations and be compliant with Health Service standards and guidance or be subject to derogations approved through formal governance. Services need to be located in accessible locations and their use maximised for efficiency. Buildings should provide a pleasant and comfortable working environment that supports the retention of workforce, both clinical and non-clinical.

The estate must support the Trusts' commitment to equality and diversity, providing appropriate access and facilities to those staff and patients with additional needs.

Both Trusts' must fulfil their obligations to meet the governments Net Zero Carbon targets for the NHS. For the emissions that are control directly (the NHS Carbon Footprint), the NHS must reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.

2.2 Dorset Picture

Dorset HealthCare and Dorset County Hospital are part of the Dorset Integrated Care System. The ICS vision, set out in their strategy, is that Dorset become the healthiest place to live. The local context is a growing and aging population with increasingly complex needs.

Due to the nature of the delivery footprint, both Dorset HealthCare and Dorset County Hospital already work with many stakeholders across Dorset in sharing accommodation, whether Acute service, Community and Mental Health Services, GP's, Voluntary organisations, councils as well as private landlords to ensure that services are delivered from locations that best meet the needs of the patients and that corporate functions use the most cost-efficient space.

The Dorset ICB published their infrastructure strategy in July 2024. The aim of the strategy is to better address demand and reduce health inequalities – particularly to support out of hospital acute care and to help reduce demand for hospital space via improved prevention and provision of alternative estates options. This provides a solid foundation for the DHC/DCH Infrastructure strategy and E&F transformation programme.

Whilst Dorset County Hospital provides a range of clinical services for people who live mainly in west, mid and north Dorset, Dorset HealthCare provide community and inpatient physical and mental health services across the whole of Dorset and beyond. This footprint

provides opportunities for sharing space in buildings, removing duplication and corresponding overhead costs. The review takes these opportunities one step further in looking for other ways to provide efficiencies which will provide further financial sustainability for both Trusts.

Both Trusts have introduced smarter working as part of ensuing that building use is maximised, avoiding heating and lighting spaces that are not fully occupied, and changed how teams work together to reduce their physical space requirements.

The long term aims of this plan are to continue this process to ensure that services are delivered from the most appropriate location, with the lowest overall cost.

2.3 Our Trusts

The focus of this plan is in ensuring that the buildings we deliver services from:

- **Support high quality, safe and effective care:**
  - By providing capital works that meet HTM & HBN requirements
  - By delivering an effective, proactive and cost-efficient maintenance regime
  - By providing compliant, cost-effective support services such as cleaning, meals and linen
  - Ensuing environmental sustainability standards across the estates
  - By ensuring that our property assets are in the right location to support the clinical delivery strategy.
- **Support the improvement of health and reduction of inequality:**
  - Ensuing environmental sustainability standards across the estates so as to minimise the effect of our presence.
  - By ensuring that property assets are in the right location to support the clinical delivery strategy.
- **Support staff retention:**
  - By providing a working environment that is safe, environmentally sustainable and where facilities for wellbeing are incorporated, improving the potential for staff to feel valued and recommend each Trust as a place to work.
  - Providing opportunities for gaining additional knowledge and training by working across both Trusts infrastructure
- **Maximise the value of our collective resources and live within our means:**
  - By sharing space in buildings to avoid duplication of overhead costs
  - By sharing externally provided digital systems to minimise the overhead costs of running the Trusts
  - To share contracts for services to maximise any discounts for throughput
  - To share technical resources to maintain standards
  - To improve resilience by having a wider number of resources with shared expertise
- **Collaboration is the accepted way we work:**
  - By sharing externally provided digital systems to minimise the overhead costs of running the Trusts
  - To share contracts for services to maximise any discounts for throughput
  - To share technical knowledge to maintain standards

- Combining some delivery to cover both Trusts, providing business continuity

- **Continuously Improving:**
  - To share technical knowledge to maintain and further develop standards

2. Engagement

3.1 Key Stakeholders

The success of the Infrastructure Enabling Plan relies on collaboration with a broad range of stakeholders who will play a critical role in shaping and implementing its objectives. These stakeholders include:

- **Clinical Stakeholders:** Clinical teams will be integral to ensuring that infrastructure improvements align with patient care needs. Engagement with medical staff, nurses, and allied health professionals will help to shape facilities that enhance clinical workflows, improve patient safety, and support efficient service delivery.

- **Patients and Service Users:** Patients and service users are at the heart of this transformation. Their experiences, accessibility requirements, and feedback will inform decisions about estate improvements, ensuring that healthcare facilities are welcoming, fit for purpose, and located in areas that maximise accessibility.

- **Local Authorities and NHS Partners:** Local councils (Dorset County Council, Bournemouth, Christchurch & Poole Council), Integrated Care Systems (NHS Dorset ICS), and other NHS partners will be engaged to align estate planning with broader healthcare strategies. This collaboration ensures that estate developments are integrated into the wider health and social care landscape, promoting efficiencies and reducing duplication of resources.

- **Staff and Workforce Representatives:** The infrastructure plan must support and enhance the working environment for clinical and non-clinical staff. Trade unions, staff networks, and employee representatives will be consulted to ensure that workplace improvements contribute to staff retention, well-being, and productivity.

- **Community and Voluntary Sector Partners:** Community groups, charities, and voluntary organisations provide valuable insights into local healthcare needs. Engaging these groups will help shape estate decisions that benefit wider community health and well-being.

3.1 How the Plans will work together

The joint infrastructure plan will be informed by the clinical plan and strategy for location of the service provision.

From a Capital, Estates and Facilities perspective change can be delivered seamlessly with other plans, albeit that some of the more efficient ways of working will be subject to confirmation by other areas of the Trust.

As part of the baseline assessment, 'Where we are now', a full audit of utilisation of sites is being undertaken, survey information into the condition through the 6-facet survey will provide detail of the condition of the estate's assets. Whilst some efficiencies are expected through improvements in utilisation as a result of this, the key to the 'right estates solution' will be the clinical requirements.

3. Alignment with the Strategic Objectives

Most of the benefits that have been identified as part of this plan support directly or indirectly across all of the objectives.

Care:

- Providing a clean, safe, well-maintained environment
- Aligning infrastructure/assets to clinical priorities. Support delivery of joint clinical strategies.
- Enhanced infrastructure and compliance to ensure safety and increase the quality and outcomes of care.

Communities:

- Supporting the operational strategies to divest of property that is not located to the benefit of communities and to acquire space or properties to deliver services in the most appropriate locations
- Developing "one public estate" opportunities, to serve broader community needs.
- Addressing health inequalities through integrated neighbourhood services (right care, right time, right place).
- Developing social value through local supply chain.

Colleagues:

- Providing a working environment that is safe, environmentally sustainable and has suitable wellbeing spaces
- Reducing dependence on outdated facilities to improve staff morale.
- Aligning space usage to modern ways of working
- Key worker housing will support recruitment and retention

Sustainability:

- Developing our built environment and transport services to be as environmentally sustainable as possible.
- Making use of cost-effective contracts across both Trusts.
- Sharing expertise, digital systems and support functions to maintain efficiency and build in business continuity.
- Meeting net zero carbon obligations
- Improving the value for money of infrastructure, measured by key metrics from the hospital.

4. Priorities

The benefits identified will be prioritised based on:

Care:

- Improved access to the right care, at the right time, in the right place.
- People are equal partners in their care and have a positive experience.
- Patient and service users are always safe in our care.

Communities:

- Improving population health and wellbeing through joined up working across health and care to reduce variation in provision, access and experience.
- People and communities involved in shaping the location and requirements of their health and care facilities.

Colleagues:

- Improved feeling of belonging and inclusivity among colleagues.
- A sustainable workforce with the right skills now and for the future.
- Provides a positive working experience.

Sustainability:

- Releasing time to care through improved processes, skill mix and digitally enhanced technology.
- Sustainable models that optimise use of the available resources.
- Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset
- Minimise our negative impact on public health and the environment.

5. Impact

- **Care**
  - **Improved estate related metrics (e.g. quality, safety, compliance, environment and accessibility) for patient satisfaction.**
  - Reduction in reactive incidents related to poor infrastructure e.g. maintenance failures, accessibility issues.
  - Increased compliance with national healthcare infrastructure standards (HTM & HBN) to deliver high-quality care facilities.
  - Alignment of clinical space utilisation, with patient demand, improving patient outcomes, waiting times and experience.

- **Communities**
  - Locating healthcare services in areas that best serve patient needs, improving accessibility.
  - Facilitating benefits associated with clinical service model development, such as integrated neighbourhood teams.
  - Supporting initiatives such as the "One Public Estate" program to integrate healthcare facilities with other public services through increased co-location of services with social care, mental health and community well-being hubs.
  - Addressing health inequalities by providing appropriate, well-maintained spaces for all demographics,

including those with additional needs.
  - Adoption of **inclusive design principles**, such as dementia-friendly layouts and sensory spaces.

- **Colleagues**
  - **Improvement in staff satisfaction scores related to workplace environment and wellness facilities**.
  - Reduction in **reported workplace safety incidents and facility-related complaints**.
  - Increase in **staff productivity and retention rates** in newly upgraded facilities.
  - Growth in **cross-organisational training and workforce development initiatives.**

- **Sustainability**
  - **Decreased maintenance costs** due to improved infrastructure reliability.
  - Improved balance between proactive and reactive delivery generating efficiencies
  - **Cost savings in procurement and operational efficiencies.**
  - **Reduction in service disruptions** caused by estate-related issues.
  - Emphasis on skills and technical training to retain and grow support workforce
  - Improved **building energy performance (EPC ratings)** and use of renewable energy sources.

It is hoped that the majority of the changes will be seamless, having a positive impact on the patients experience in that they will attend buildings that are clean, safe and well maintained; and hopefully in a location that works for them, so that they can focus on their care not the space it is delivered within.

Staff should notice changes; they should be comfortable in their working environment and more confident that the proactive measures in place are minimising the number of reactive maintenance calls. They should have access to wellbeing spaces and work in buildings that support environmental sustainability.

Staff will also be able to engage fully with the pathways to Net Zero with a wide range of interactions that will support delivery.

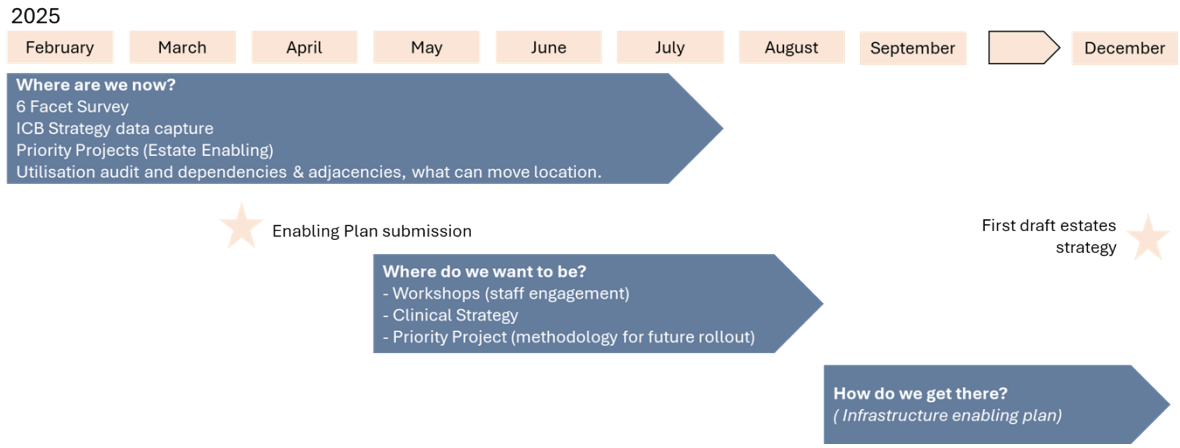
6. Roadmap

The immediate deliverable timelines are as follows:

December 2024 to January 2025	Workshops to identify potential ben
30 Jan 2025	Initial review of identified benefits and options appraisal
14 Feb	Draft delivery report
24 Feb	SRO feedback on plan
10 Mar	Final delivery report

14 Mar	SRO approval
17 Mar	F&P CIC meeting

With the expected process to follow the indictive timeline below:

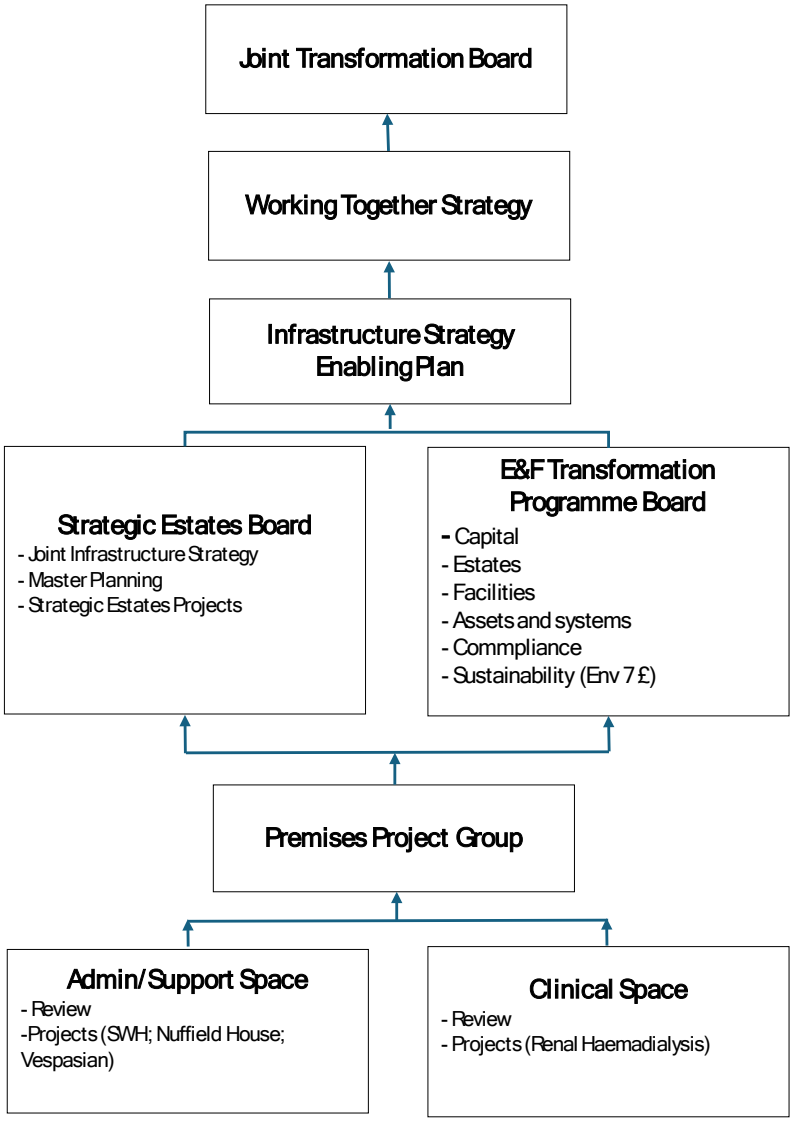


Whilst there are a number of benefits identified, as seen in the Benefits Assessment Report which can be found at Appendix A, which can be started and, in some cases, delivered within 12 months, the overall programme benefits realisation will be across a number of years, for example a change to a contract would be dependent upon existing contractual timescales. Changes to buildings will be constrained by the Capital timetable and funding, changes to leases by the existing lease terms and conditions.

We have therefore developed a Benefits Realisation Plan, at Appendix B, which will be owned by the Director of Estates & Facilities, this document will become part of the monthly Leadership Meeting for review and progress, allowing the relevant level of operational, financial and people focus to drive forward the delivery and to identify additional benefits that become apparent throughout the coming years.

7. Governance Cycle

The governance structure is set out below. Each E&F Transformation Plan will be reviewed by the divisional lead group – Service Director, Deputy Service Director from DHC and DCH. The Chief Finance Officer will then give final approval as SRO. Projects requiring funding will need approval according to Trust SFIs, including the Finance & Performance Committee In Common. Benefits will be identified at workstream level and collated within a benefits realisation plan



8 Recommendations

8.1 The Committee is recommended to:

a. Receive the report for **information**
b. Receive the report for **assurance**
c. **Approve** the report

Name and Title of Author: **David McLaughlin, Joint Directors of Estates and Facilities**
Tristan Chapman, Director of Strategic Estates

14 March 2023

Appendices

Appendix A **Benefits Assessment Report**
Appendix B **Benefits Realisation Plan**

Dorset County Hospital
Dorset HealthCare

Clinical & Quality Enabling Plan

27 March 2025

Healthier lives Empowered citizens Thriving communities

Background and Context

National context

The 10 Year Health Plan:

- Key messages - improve access to care; shift care from hospitals to communities; shift from analogue to digital, shift from sickness to prevention

Lord Darzi Review of Health & Care:

- Key messages - re-engage staff and empower patients; expand GP, MH and Community Services; improve productivity; tilt towards technology; rebalance resources; get people back to work

2025/26 priorities and operational guidance:

- Key messages: NHS productivity to deliver more care; improve experience of care; increased local autonomy; lay the foundations for future reform; be ambitious

National context (continued)

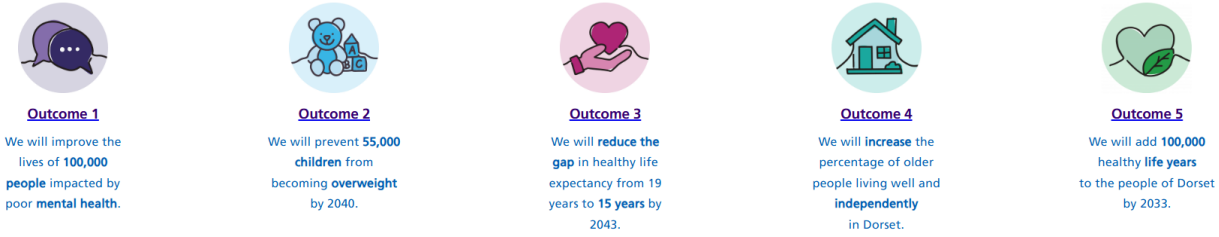
Population Health and Health Inequalities guidance e.g. King's Fund, CORE20+5, NHSE

- Key messages: The NHS role - working with people and communities, statutory and voluntary partners - in (1) prevention, (2) delivering appropriate health and care services, and (3) as an Anchor Institution

System context

Working Better Together and Joint forward Plan (NHS Dorset)

- Key messages: prevention and early help, thriving communities and working better together



Working together, improving lives

We work specifically towards the 'Care' and 'Communities' objectives in the Joint Strategy which sets out the following priority areas:

Strategic Objectives	Headline	Ambition	Strategic Goals Medium term 3 – 5 years	Breakthrough Objectives 12 – 18 months (Looking for a few metrics to highlight overall progress)
Care 	We provide safe, compassionate care	Improved access to the right care, at the right time in the right place People are equal partners in their care and have a positive experience Patients and service users are always safe in our care	• Patient national constitutional standards for planned and emergency care at met • Patient, family and carer experience is excellent • Hospital acquired infections are in the lowest quartile nationally	• Improved performance against patient national standards for access Mental Health, Planned, Emergency, Community and Children & Young People • Improved annual survey Patient Experience (Focus changes every year) • Patients, families and carers complaints are in the lowest quartile nationally
Community 	We help build strong communities where people live well and are healthier	Improved population health and wellbeing through joined-up working across health and care. People staying well through prevention, detection and early intervention, with more control over their own health. People and communities involved in shaping health and care services	• Dorset population is highly activated with their care and wellbeing • Federation spend moved from hospital to neighbourhoods to reduce admissions • Everyone who needs one, has an Anticipatory Care Plan– c40,000 plans (new metric)	• More patients are engaged with their health and wellbeing • More services are co-designed and produced with people and partners • Investment in Integrated Neighbourhood Teams

We also play a supporting role in the delivery of the other two objectives – 'Colleagues', and 'Sustainability'.

Healthier lives Empowered citizens Thriving communities

Developing the Clinical and Quality Plan

Supported by the Transformation Team, and in collaboration with colleagues leading on the other enabling plans, the Clinical and Quality Plan has been developed as follows:

- Rapid desktop review of national and local context, and work underway and planned
- Review of strategic drivers – to understand the steps needed to achieve the ambition
- Conversations with clinical, quality and operational staff across both Trusts – guided by time, resource and availability - with a focus on building awareness of plan development and further listening
- Guidance from the Joint Clinical Leadership Group, established to provide advisory support – and feedback from wider leadership fora e.g. Joint Senior Leadership Team, DCH Clinical Leads, quality and divisional directorates
- Feedback from the Transformation and Partnerships Committee in Common

This is expected to be an evolving plan which iterates to respond to the changing strategic and local context. We will continue to engage with all the above to flex the plan to changing needs.

Staff Voice – Feedback themes

There were four main feedback themes from conversations with staff. For further comments, please see Appendix.

1. **Operational** challenges – and opportunities

When St Anne's patients attend UHD, we can see their records. For DCH, we have to telephone.

Could our haematology patients access their own blood results, to free us up?

2. The potential from **partnership** working – for some, clarity needed on the focus and how

We have excellent examples of working with social prescribing, but each team is making their own links. Could this be centralised?

I'd love to work in partnership with DHC for our [acute speciality], but I don't know what services they have.

3. The need to focus on **'populations'** – for some, clarity needed on what this means in practice

We see patients in their homes and could be 'making every contact count' to support their wider health, wellbeing and social needs.

Staff are fire-fighting in ED. We need to be clear what this means for them.

4. **Questions** about the Plan and Implementation

How does this relate to other plans? [e.g. Quality priorities, INTs] and reporting to the Board?

Why will this be different to any other strategy? Prioritising is an issue.

10 Clinical and Quality Priorities

Strategic Objective	Ambition	Priority Plans – *supported by more detailed plans across the life course*
Care 	Improved access to the right care, at the right time, in the right place	1. Deliver Future Care
		2. Planned Care Delivery Programme
		3. Mental Health Crisis Pathway
		4. Deliver Integrated Services
	People are equal partners in their care and have a positive experience	5. Embed Patient Carer Race Equality Framework
	Patients and service users are always safe in our care	6. Embed Patient Safety Incident Response Framework
		7. Single Electronic Health Record
Communities 	Improved population health and wellbeing through joined up working across health and care	8. Deliver Integrated Neighbourhood Teams
	People staying well through prevention, detection and early intervention, with more control over their own health	9. Develop New Pathways of Care (shift from hospital to community)
	People and communities involved in shaping health and care services	10. Co-production and co-design in all we do

Healthier lives Empowered citizens Thriving communities

Clinical Transformation Framework

Three Questions of Clinical Transformation	Achieved through	How
Are we being effective and productive? 	Transformation of clinical pathways, systems and processes	Developed with staff and patients to improve: • Patient safety • Information sharing • Operational efficiencies • Empower and enable self-care
Are we working in partnership? 	Working to deliver safe, personalised and equitable care, closer to home with parity of esteem	Sustained research and improvement culture by working with: • Those with lived experience • Carers and families • Statutory and voluntary sector partners • Higher education institutions • Our communities
Are we improving population health and tackling health inequalities? 	Improving the physical and mental health and wellbeing of our communities and reducing health inequalities	Enabling good health and wellbeing by designing services to: • Focus on prevention, improving health and recovery • Meet the needs of our populations • Fulfil our potential as an anchor institution

Delivery and Monitoring

The Plan will be **delivered** through:

- the 10 priority plans; and
- the Joint Transformation Plan

It will be **enabled by** implementation of the Joint Improvement Framework.

The Plan will be **monitored** through

- the Strategy Dashboard, and
- key metrics to be agreed for each of the ten plans.

Dorset County Hospital
Dorset HealthCare

Finance and Procurement Enabling Plan

24 March 2025

Healthier lives Empowered citizens Thriving communities

Finance & Procurement Enabling Plan

The Finance and Procurement enabling plan covers the following areas:

- Financial accounts and systems
- Management accounts
- Income and costing
- Strategic finance/Planning
- Commissioning and contracting
- Procurement
- Logistics
- ESR & E-Roster (DCH only)

- Support service function to multiple specialties across both Trusts – **make a difference to patients, staff, communities and partners**

- Messaging & embed enabling plan across Finance & Procurement teams

- Alignment to strategic objectives – **Care, Community, Colleagues, Sustainability**

- Dovetail with other Enabling Plans – **Clinical & Quality, Digital, People, Strategic Estates**

- **Understand where are we now, where do we want to be, how do we get there, and how we measure success**

Context

National context - increasingly challenging landscape

- Cost base reduction of at least 1% and 4% improvement in productivity, in order to deal with demand growth
- All NHS organisations must live within their means
- Productivity focus

Dorset context

- Financial deficit
- Increased regional and national scrutiny
- Our Dorset Provider Collaborative work to develop sustainable support services, directly impacts this plan

Organisational context

- Legally separate entities
- Dorset County Hospital – deficit organisation with cash challenge
- Dorset HealthCare – breakeven organisation with high level of vacancies
- Development of joint working and aligned processes where appropriate
- CIP scheme development, delivery and ideas share
- Triangulation of activity, workforce and financial planning

Priorities for Finance & Procurement

1. Achieving financial sustainability

- **Planning**

  Work with the Dorset system to develop financially sustainable long-term plans, that support the healthcare needs of the Dorset population

  Alignment of planning priorities across both Trusts, to ensure efficient use of resources – **support operating plans triangulated with activity & workforce**

- **Enhanced Budget management – grip & cost control focus**

  Improvement and alignment of budget setting processes

  Ongoing development and improvement of budget manager training linked to Standing Financial Instructions & scheme of delegation

- **Productivity – do more with the same**

  Shared learning between Trusts to measure and improve productivity – key focus area

- **Efficiency – do same amount with less**

  Shared approach to efficiency to address significant challenges for both Trusts – clear plans for each area, owned by each area

- **Cash management**

  Development of system wide principles to improve cashflow across all Dorset organisations

Priorities for Finance & Procurement

2. Strong financial governance

Reporting cycle

- Alignment of monthly national and internal financial reporting format across both Trusts
- Ongoing development of enhanced monthly financial information supplied to operational areas, to support financial awareness and involvement

Trust governance

- Board Assurance Framework
- Alignment of CIP approach, and capital oversight across both Trusts
- Development of Finance and Performance Committee in Common oversight
- Benefits realisation core BAU

Priorities for Finance & Procurement

3. Supporting and developing our staff

- Review of joint roles, with opportunities for development and resilience across both Trusts
- Clear links supporting the Trust for the benefit of patients and service users
- Achievement of One NHS Finance accreditation
- Ongoing work to support development of a Dorset wide Procurement function

Engagement and Measures

- **Engagement** has taken place via transformation team organised regular leads meetings and senior leadership presentation, including ‘world café’ style feedback gathering
- In addition to this, links with other enabling plan leads have been made or are in train to ensure dovetailing of priorities
- Ongoing engagement will reflect the iterative process of delivery and noting the challenging landcape over the coming months and years for each organisation and the Dorset system
- The following slides detail per service line specific examples of **measurable KPIs** to assess and support implementation of the plan
- Specific key performance metrics developed per service line to monitor deliverables
- Reinforce grip & control measures
- Ongoing engagement to refine

Key Metrics – Management Acccounts

Area	Metric	Target	Data Source	Expected Outcome - what does 'good' look like	Implications of not meeting target
Finance - Management Accounts	% of budget managers met monthly to review statements & position (by areas)	75%	Budget manager log	Supports cost control & effective budget manager support, not possible to meet 100% due to timing - annual leave/sickness etc	Potential poor experience for budget managers, cost control, efficiency focus potential to be reduced
Finance - Management Accounts	% of budget managers attending finance training (by area)	100%	Budget manager log	Supports cost control & effective budget manager support - measure over course of financial year, rolling increase expected	Lack of shared consistent financial training and knowledge share
Finance - Management Accounts	% of TRAC queries responded to within 3 working days (by area)	75%	TBC - under review	Supports improved pace of change/productivity, unlikely to reach 100% due to cover/timing - sickness/annual leave etc	Delays in recruitment progression, productivity implications

Key Metrics – Financial Accounts

Area	Metric	Target	Data Source	Expected Outcome - what does 'good' look like	Implications of not meeting target
Finance - Financial Accounts/Payables	% of invoices paid with specified payment terms	100%	EFIN/NHSI Return	Supports sound financial management	Reputational, potential poor payment practice, potential fines and other consequences

Key Metrics – ESR

Area	Metric	Target	Data Source	Expected Outcome - what does 'good' look like	Implications of not meeting target
Finance - Payroll	% of payroll paid on time and accurate (by area)	100%	Payroll reporting files	Aiming to pay everybody on time and accurately, split by area to highlight where additional focus/support may be required	Poor experience for staff, increase workload for ESR and Payroll teams, reduces productivity correcting errors
Finance - Payroll	% of manual adjustments/corrections required to payroll (by area)	5%	Payroll reporting files	Eliminate regular manual adjustments or corrections by getting correct first time	Poor experience for staff, increase workload for ESR and Payroll teams, reduces productivity

Key Metrics - Procurement

Area	Metric	Target	Data Source	Expected Outcome - what does 'good' look like	Implications of not meeting target
Procurement	% of spend made on purchase order (PO)	90%	EFIN/Supplies	Supports sound financial management	Multiple invoices without prior review, planning, cost control, forecast delays/implications
Procurement	% of Supplier spend made locally	18%	EFIN/Supplies	Supports social value pledge	Not in line with Trust's social value pledge
Procurement	% of Supplier spend made regionally	15%	EFIN/Supplies	Supports social value pledge	Not in line with Trust's social value pledge

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Report to	Board of Directors, Part 1	
Date of Meeting	08 April 2025	
Report Title	DCH SubCo Performance Report	
Prepared By	Andrew Harris, Superintendent Pharmacist	
Approved by Accountable Executive	Nick Johnson, Claire Abraham (DCH SubCo Directors)	
Previously Considered By	DCH SubCo Ltd Board meeting, 17 March 2025 Finance and Performance Committee in Common, 24 March 2025	
Action Required	**Approval**	-
	Assurance	-
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality: the principal activity of the company is to provide outpatient pharmacy services to Dorset County Hospital NHSFT.	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	DCH SubCo Ltd continues to work with the shareholder (Dorset County Hospital NHSFT) in the provision of its services.	

Executive Summary

Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

A review of dispensing activity was undertaken in June 2023 in conjunction with the Chief Pharmacist and Lead Cancer Nurse to identify activity that could be relocated elsewhere (main hospital pharmacy or community pharmacy) to manage the increasing workload.

All contractual KPIs year to date are green.

Incidents

No dispensing errors have left Fortuneswell Pharmacy in financial year 2024/25

Complaints

Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the

original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.

- HM Treasury commenced a consultation in August 2020 on “VAT and the Public Sector: Reform to VAT refund rules”. This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

Recommendation

Members are requested to:

- Receive the report for **information**

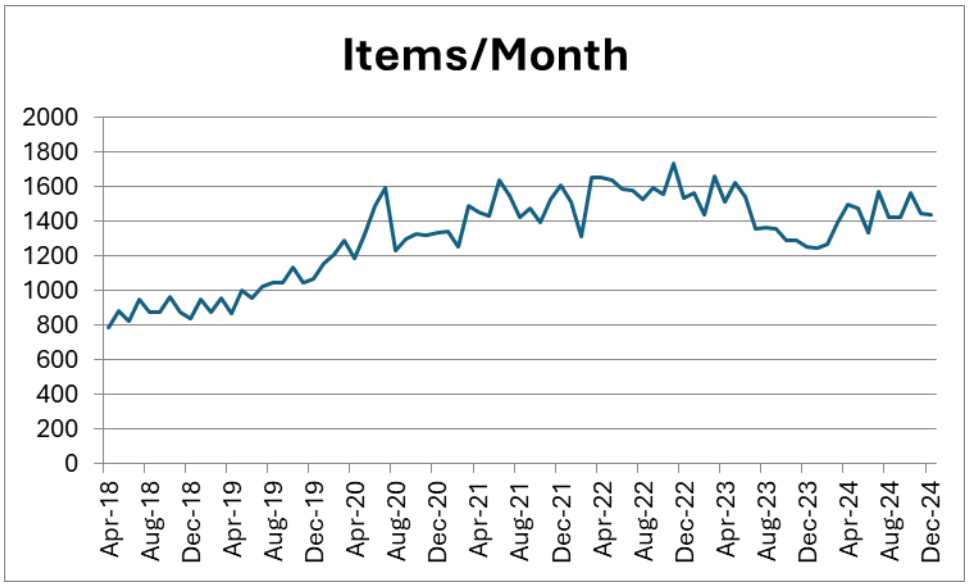
Performance Report

Andrew Harris
Superintendent Pharmacist
January 2025

Key Performance Indicators (KPIs)

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Total Number of Customers per Month	172	147	129	169	176	144	142	143	135
Total Items Dispensed	1496	1478	1338	1575	1426	1422	1567	1444	1439
Average Items/day	74.8	70.4	66.9	68.5	67.9	67.7	68.1	68.8	72.0
No. of same day Prescriptions	243	214	213	223	179	259	187	208	228
No. of Advance Prescriptions	493	506	413	549	351	385	481	421	444

Activity levels from April 2018 to current:



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All contractual KPIs year to date are green.

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.67%	0.88%	0.90%	0.95%	0.98%	0.91%	0.96%	0.97%	0.83%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	0	0	0	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9%	99.47%	99.80%	99.78%	99.49%	99.23%	99.86%	99.87%	99.58%	99.65%
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%
All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	97.6%	98.2%	96.9%	96.9%	96.0%	96.4%	96.5%	95.3%	97.1%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 100% (ii) 100%	(i) 100% (ii) 97.7%	(i) 98.3% (ii) 97.5%	(i) 99.3% (ii) 97.4%	(i) 100% (ii) 97.7%	(i) 100% (ii) 93.7%	(i) 99.1% (ii) 98.3%	(i) 98.5% (ii) 93.4%	(i) 100% (ii) 99.3%

Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0	0	0	0	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0.05% - 0.099%	> 0.1%	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Waste/Expiry management *	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£8.87	£6.25	£0.00	£8.41	£0.04	£3.35	£0.00	£0.00	£42.11

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Month End Stock Value £k (i/c VAT)	266	374	357	407	263	337	373	414	287

Incidents
No dispensing errors have left Fortuneswell Pharmacy in financial year 2024/25

Complaints
Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.